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The Geography of Abortion Rights

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Abstract

Total or near-total abortion bans passed in recent years have garnered tremendous public attention. But another recent wave of more modest-looking abortion restrictions consists of laws regulating the geography of abortion provision through management of spaces, places, and borders. In the 1990s and early 2000s, numerous states adopted laws regulating the physical spaces where abortions can be performed. These laws include mandates that abortions be performed in particular kinds of places, such as ambulatory surgical centers, or that abortion-providing facilities have agreements in place with local hospitals. One consequence of such regulations has been to reduce the availability of abortion services within the geographical borders of a particular state and to require people to travel out of state in order to terminate a pregnancy. Other abortion controversies, too, have foregrounded the significance of state and even national borders, as in the cases of unaccompanied immigrant minors who sought abortions while in the custody of the U.S. Government. Thus, an entire subset of abortion restrictions intentionally targets the geography of abortion provision, inevitably impacts the geographical distribution of abortion services, or both. Yet, the geographical dimension of abortion restrictions has gone largely unappreciated in the legal literature. This Article thus aims to provide an overview of the geography of abortion regulation. It first considers the unique impact and attractiveness of spatial regulations, demonstrating that spatial regulations differ from other forms of abortion regulation in their tendency to exploit and aggravate preexisting social inequality in ways that make it appear natural or unavoidable. Second, this Article considers the jurisprudential implications of this "spatial turn" in three specific areas: the right to travel, private non-delegation doctrine, and the concept of viability in abortion doctrine.

THE GEOGRAPHY OF ABORTION RIGHTS

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The Geography of Abortion Rights

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Introduction

Public attention has focused on the infringement of reproductive liberty in the form of total or near-total abortion bans passed in recent years.[2] But another recent wave of more modest-looking abortion restrictions consists of laws regulating the geography of abortion provision through the management of spaces, places, and borders. In the 1990s and early 2000s, numerous states adopted laws regulating the physical spaces where abortions can be performed.[3] These laws contrast with laws regulating the abortion process itself, such as waiting periods and parental consent requirements for minors. Laws regulating abortion spaces include mandates that abortions be performed in particular kinds

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[1] Associate Dean for Research and Faculty Development and Judge Ben C. Green Professor of Law, Case Western Reserve University School of Law. An early version of this paper was presented the Health Law Professors conference in Cleveland, Ohio in 2018. I would like to thank Glenn Cohen, Jonathan Entin, Marc Spindelman, and Mary Ziegler. Becca Kendis provided excellent research assistance.

[2] In 2019, nine states passed laws banning abortions at a point in pregnancy that is well before viability. Alabama enacted a total ban on abortion; Georgia, Kentucky, Louisiana, Mississippi and Ohio banned abortion when a fetal heartbeat can be detected (as early as six weeks of pregnancy); Missouri passed a law banning abortion at eight weeks gestation; and Arkansas and Utah banned abortion at 18 weeks. *See generally* K.K. Rebecca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 29, 2019); Elizabeth Nash et al., State Policy Trends 2019: A Wave of Abortion Bans, but Some States Are Fighting Back (Dec. 10, 2019), guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back. North Dakota and Iowa had previously passed first-trimester abortion bans. Elizabeth Nash, A Surge in Bans on Abortion as Early as Six Weeks, Before Most People Know They Are Pregnant (updated May 30, 2019), https://www.guttmacher.org/article/2019/03/surge-bans-abortion-early-six-weeks-most-people-know-they-are-pregnant. None of these bans is currently in effect.

[3] Such laws existed previously, but a large number were adopted in the 1990s and 2000s. *See, e.g.*, Mary Ziegler, *Liberty and the Politics of Balance: The Undue-Burden Test After* Casey/Hellerstedt, 52 Harv. C.R.-C.L. L. REV. 421, 451 (2017) (hereinafter Ziegler, *Liberty*); Alan Guttmacher Inst., TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price, Guttmacher Policy Review (June 25, 2013), https://www.guttmacher.org/gpr/2013/06/trap-laws-gain-political-traction-while-abortion-clinics-and-women-they-serve-pay-price.

of places, such as ambulatory surgical centers, or that abortion-providing facilities have agreements in place with local hospitals.[4]

Some, known as TRAP laws (for Targeted Regulation of Abortion Providers), impose particularly onerous restrictions only on abortion providers and not on facilities providing comparable health care services.[5] Justified as being necessary to protect the health and safety of patients, these laws are, in part, a result of anti-abortion activists' turn toward "woman-protective" arguments.[6] Such arguments fed into a broader incremental strategy for undermining *Roe v. Wade*'s[7] constitutional protection for abortion by winning public support for the anti-abortion cause, especially in light of the failure of other anti-abortion strategies, and by exploiting the ambiguities in the Supreme Court's *Planned Parenthood v. Casey*[8] precedent.[9]

But geography and space are implicated in abortion laws in ways that go beyond the narrow category of restrictions described above. Most obviously, one (largely intended) consequence of facility regulations has been to reduce the availability of abortion services within the geographical borders of a particular state and to require some people to travel out of state in order to terminate a pregnancy. As discussed below, state borders come to play a significant role in courts' evaluation of the constitutionality of these laws. Other abortion controversies, too, such as the case of unaccompanied immigrant minors who sought abortions while in the custody of the U.S. Government, have foregrounded the significance of state and even national borders.[10]

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[4] Alan Guttmacher Inst., Targeted Regulation of Abortion Providers, https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers

[5] *See, e.g.*, Mandee Silverman, *RU-486: A Dramatic New Choice or Forum for Continued Abortion Controversy?*, 57 N.Y.U. ANN. SURV. AM. L. 247, 280 (2000).

[6] Ziegler, *Liberty*, *supra* note 3, at 447.

[7] 410 U.S. 113 (1973).

[8] 505 U.S. 833 (1992).

[9] Ziegler, *Politics of Balance*, *supra* note 3, at 441-42, 447; Mary Ziegler, *Liberty:* Whole Woman's Health v. Hellerstedt *and the Future of Abortion Law*, 2016 SUP. CT. REV. 77, 97-101; *see also generally* Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions under* Casey/Carhart, 117 YALE L.J. 1694, 1707-32 (2008). Siegel discusses the shift toward incrementalism and a focus on "woman-protective" legislation in the context of "partial-birth" abortion bans. As I discuss below, *infra* Part XX, such bans can be considered as a species of spatial regulation.

[10] Garza v. Hargan, 304 F. Supp. 3d 145, 151 (D.D.C. 2018), aff'd in part, vacated in part, remanded sub nom. J.D. v. Azar, 925 F.3d 1291 (D.C. Cir. 2019).

Finally, another set of abortion regulations may be understood as spatial regulations, although they are not usually described as such. These are laws that involve visual and narrative mapping of physical spaces within the woman's body. In this category are laws that require an ultrasound before an abortion, often accompanied by a description of the fetal anatomy—a delineation of internal anatomical space projected, like a map, on the screen. The federal Partial Birth Abortion Ban Act is another example of a law that regulates the geography of women's[11] bodies, by designating internal "anatomical landmarks" as trigger points for state control of the abortion procedure.[12]

Despite its apparent significance, the geographical dimension of abortion restrictions has gone largely unappreciated in the legal literature.[13] This article thus attempts a comprehensive overview of the

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[11] This Article occasionally uses "women" as shorthand for individuals who may seek abortion, because abortion restrictions disproportionately affect women and are often targeted specifically at women, while recognizing that individuals of all gender identities, including transgender men and non-conforming people, may become pregnant and seek abortions.

[12] 18 U.S.C. § 1531. *See infra* ___ for a discussion of the Act's "anatomical landmarks."

[13] There are, of course, a few exceptions. A handful of articles from the 1990s and early 2000s consider the constitutional issues surrounding hypothetical extraterritorial abortion restrictions. *See, e.g.*, Susan Frelich Appleton, *Gender, Abortion, and Travel After* Roe*'s End*, 51 ST. LOUIS UNIV. L.J. 655 (2007); Richard H. Fallon, *If* Roe *Were Overruled: Abortion and the Constitution in a Post-*Roe *World*, 51 ST. LOUIS UNIV. L.J. 611 (2007); Seth F. Kreimer, *"But Whoever Treasures Freedom…": The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907 (1993); Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451 (1992). This somewhat narrow issue is addressed below in Part V.B. More recently, Professor Glenn Cohen has discussed abortion, among other medical procedures, in his work on circumvention tourism, with a primary focus on international rather than domestic travel. *See, e.g.*, I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM, LAW, AND ETHICS 318-21, 347-56 (2015); I. Glenn Cohen, *Circumvention Tourism*, 97 CORNELL L. REV. 1309, 1363-73 (2012). Lisa Pruitt and Marta Vanegas have written incisively about the role of "urbanormativity" and spatial privilege in shaping the judicial understanding of the burdens imposed on women—particularly rural women—by abortion restrictions. Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER, L. & J. 76 (2015); *see also* Lisa R. Pruitt, *Gender, Geography & Rural Justice*, 23 BERKELEY J. GENDER L. & JUST. 338 (2008). And Mae Kuykendall discusses abortion restrictions, among other contexts in which the concept of place plays a role in law. *See* Mae Kuykendall, *Restatement of Place*, 79 BROOKLYN L. REV. 757, 787-793 (2014); *see also* B. Jessie Hill, *Dangerous Terrain: Mapping the Female Body in* Gonzales v. Carhart, 19 COLUM. J. GENDER & L. 649 (2010) (discussing the way in which *Gonzales v. Carhart* presents the woman's internal

geography of abortion regulation, focusing primarily on two questions. The first question pertains to the unique impact of spatial regulation: How are the effects of spatial regulation different from those of other forms of abortion regulation? The answer proposed by this Article is that regulating place is a way of subtly drawing lines of social exclusion and inclusion and reinscribing social inequality along the dimensions of gender and socio-economic status, while at the same time concealing this operation. This facet of spatial regulation has made it particularly attractive to advocates and legislators seeking to restrict access to abortion. Moreover, borders—whether geographical or anatomical—have the capacity to create and reinforce politics of inclusion and exclusion not so much because of whom they include or exclude, but because the ability to manipulate those borders is itself a key mechanism of control. Whether borders are being strengthened or made more permeable, the key fact is not the existence of the border but rather its deployment for political and moral ends.

The second question concerns the implications of this "spatial turn" for the development of abortion jurisprudence (and perhaps other areas of constitutional jurisprudence as well). This Article suggests that there are at least three ways in which the spatial perspective on abortion regulation might affect constitutional doctrine. First, placing substantive due process jurisprudence pertaining to spatial regulation side-by-side with right-to-travel and equal protection jurisprudence suggests a deep connection between the substantive due process jurisprudence of reproductive liberty and the constitutional concept of equal citizenship. Importantly, it suggests that states may have a constitutional obligation to ensure a certain, non-negligible level of abortion access for their residents. Second, a fresh understanding of spatial regulation might encourage constitutional scholars to reconsider the conventional understanding of state action. The taken-for-grantedness of physical space often renders invisible the action of the state in creating, manipulating, and reinforcing borders. On-the-ground effects that are driven by state action nonetheless appear to be private decisions for which only private individuals are responsible. A clear-eyed understanding of spatial abortion regulation should aid courts and advocates in counteracting this appearance through a revival of one line

anatomy as a physical terrain). There is, however, significant room for expansion on the topic of geography in relation to abortion rights. In fact, I owe a debt of gratitude to Mae Kuykendall for encouraging me to expand on this topic.

of of non-delegation doctrine, which forbids private entities from exercising unreviewable and standardless power over individuals' constitutional rights. Third and finally, this Article suggests that a healthy degree of skepticism is appropriate with respect to claims about supposedly fixed or objective borders, even in the medical realm. Thus, judges should view with great skepticism claims that scientific advances have undermined the premises supporting the Supreme Court's reliance on viability as the appropriate borderline for when abortion can be prohibited.

This Article proceeds as follows. Part I lays out the central theoretical premises of this Article, examining how borders and travel are related to sovereignty and to women's liberty. Part II then discusses the current state of abortion facility regulation in the U.S. That Part argues that abortion facility regulation has the effect of contributing to the unequal citizenship of women by isolating abortion, both physically and legally, from health care generally. Moreover, one effect of onerous and discriminatory regulation of abortion facilities is to shut down abortion clinics in an attempt to create "abortion-free zones" within states. Building on this insight, Part III discusses the regulation of abortion in connection with state and national borders. It argues that such borders play an essential role in defining citizenship, and that the presumed inevitability of borders both reinforces and conceals the state's intent to remove from women one of the key attributes of citizenship. Turning to abortion's "internal" geography, Part IV next considers how abortion laws focused on women's physical anatomy function as spatial regulation, deploying the manipulation of borders as a means of sovereignty and control. Finally, Part V brings together the prior three parts by highlighting the themes that unite all three forms of spatial regulation and by suggesting some ways in which constitutional law might take account of the more problematic aspects of spatial abortion regulation.

A final introductory note: at the time of this writing, the constitutional status of the right to terminate a pregnancy appears as precarious as it has been in the years since *Roe v. Wade*[14] was decided. A Supreme Court decision in the near future could well, in one sense, render the analysis here moot, insofar as no woman will have a federal constitutional right to abortion and therefore notions of state action and equal protection deriving from that right may appear irrelevant. Spatial

[14] 410 U.S. 113 (1973).

regulations may be replaced by total abortion bans. From another perspective, however, a post-*Roe* world might only be a starker version of the world that already exists. Before *Roe*, some women had the ability to end unwanted pregnancies and others did not.[15] A woman's access to procreative liberty varied then, as now, depending on geography, as well as on social class.[16] This geographical and social inequality will likely persist, as will the constitutional questions surrounding the scope of state power, even if *Roe* does not. The U.S. may end up with a patchwork in which some states outlaw abortion in nearly all circumstances, whereas others guarantee liberal access.[17] Indeed, such questions—and the importance of geography—will only intensify as states may consider exercising their power extraterritorially.[18] The possibility of constitutional change, in fact, generates an even more pressing need for a new set of arguments with which to challenge restrictions on women's reproductive freedom, such as those presented here.

I. Spatial Regulation and the Meaning of Reproductive Liberty

Control over borders is an essential attribute of sovereignty. In controlling ingress and egress to the nation, according to traditional views of sovereignty, the state determines who is entitled to the benefits and protections of membership in a given political community;[19] it engages in acts of inclusion and exclusion.[20] In theory at least, political borders mark the point at which certain legal protections come into

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[15] *See, e.g.*, LESLIE REAGAN, WHEN ABORTION WAS A CRIME 16 (1997).

[16] *See, e.g.*, *id.* at 16.

[17] Alternately, it is possible that federal legislation will be adopted to govern access to abortion nationwide.

[18] Fallon, *supra* note 13; Appleton, *supra* note 13; *see also infra* ___.

[19] This is the classical, "Westphalian" understanding of the state, in which legal rights and remedies "are connected to, or limited by, territorial location." Kal Raustiala, *The Geography of Justice*, 73 FORDHAM L. REV. 2501, 2503 (2005); *see also id.* at 2508-11. As Kal Raustiala has shown, this conception has considerable staying power, despite the fact that it no longer reflects legal realities and lacks a rational conceptual foundation. *Id.* at 2513-28.

[20] Timothy Zick, *Constitutional Displacement*, 86 WASH. U. L. REV. 515, 526-27 (2009) ("Sovereigns use territory to control access to the critical prize of membership or citizenship…. To enforce the spatiality of citizenship and membership, sovereigns must possess the authority to control territorial borders—to repel and expel.").

effect, as well as the scope of state sovereignty or power over individuals. For example, the Fourteenth Amendment provides that "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside."[21] The Fourteenth Amendment's operation thus depends on geographical facts in its references to the location of birth and of residence, as well as to being within the "jurisdiction" of the United States. State and national borders mark the dividing line between those who are "in"—that is, entitled to the rights, privileges, and immunities of citizenship—and those who are "out."[22] Spatial regulation is therefore not only a quintessential exercise of sovereignty, but also one that is fraught with the possibility of creating and enforcing inequality.

Moreover, despite the fact that they often rely on natural features, such as rivers and mountains, state and national borders are fundamentally artificial—they are creations of law.[23] The only reason a river, or a mountain range, or a particular set of coordinates on a map has legal significance, after all, is because it was given that significance by legal actors. Perhaps recognizing this artificiality, modern legal doctrine has rejected territory as the primary basis of legal power or jurisdiction, favoring residence or citizenship instead.[24] A focus on residence or citizenship appears to entail a more consensual basis for the state exercise of power over individuals: if individuals willingly choose to live in a particular state and partake of its benefits, they should also expect to be subject to the burden of that state's rules.

The legal conception of borders thus partakes of two contradictory but often coexisting conceptions, as explained in Richard Ford's groundbreaking scholarship on geography and racial segregation.[25] In one conception, which basically aligns with the territorial conception of jurisdiction, political geography is seen as "opaque" in the sense that, like the rivers and mountains themselves, it is "inert, primordial, natural, and therefore having a natural or

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[21] U.S. CONST. amdt. XIV.

[22] *See* Zadvydas v. Davis, 533 U.S. 678, 693 (2001).

[23] Judith Resnik, *"Within Its Jurisdiction": Moving Boundaries, People, and the Law of Migration*, 160 PROCEEDINGS OF THE AM. PHIL. SOC'Y 117, 117 (2016).

[24] For helpful and concise discussions of this shift, see Cohen, *supra* note 13, at 1329-35, and Fallon, *supra* note 13, at 629-32.

[25] Richard Thompson Ford, *The Boundaries of Race: Political Geography in Legal Analysis*, 107 HARV. L. REV. 1841, 1859 (1994).

prepolitical meaning."[26] In the other conception, perhaps represented by the conceptual view of jurisdiction, space and geography are "transparent"—that is, "irrelevant, both superseded in importance by the modern technologies of transportation and communication, and insignificant and without consequences of its own."[27] Interestingly, both conceptions take responsibility away from the state for the effects of laws that rely upon geographical facts, concealing and ignoring the extent to which decisions by individuals with political power in turn shape those geographies, with predictable and often intended effects on individuals within them.

The regulation of geography is closely related to reproductive liberty in two ways. First, to the extent that the right to procreative control is understood to be a fundamental right—a basic appurtenance of citizenship[28]— state laws creating a patchwork of abortion access raise the prospect of unequal federal citizenship based on geography.[29] This reality turns on its head the Supreme Court's recognition in *Doe v. Bolton* that the right to seek abortion services is an aspect of the "privileges and immunities" of state citizenship, instead creating a form of spatial inequality.[30]

Secondly, liberty and geography are deeply intertwined. In the most basic sense, "liberty" is the liberty of movement. It is the freedom from bodily constraints and geographical barriers that prevent free motion. Indeed, according to Blackstone, "[p]ersonal liberty consists in the power of locomotion, of changing situation, or removing one's person to whatever place one's own inclination may direct, without restraint, unless by due course of law."[31] Perhaps due to its long pedigree,

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[26] *Id.*

[27] *Id.*

[28] *See* Doe v. Bolton, 410 U.S. 179, 200 (1973) (holding that a state residency requirement for abortions violates the Privileges and Immunities Clause of Article IV of the U.S. Constitution).

[29] *See, e.g.*, Jackson Women's Health Org. v. Currier, 940 F. Supp. 2d 416, 422 (S.D. Miss. 2013) (noting that the logic according to which states can avoid their responsibility to ensure protect abortion access "by merely saying that abortions are available elsewhere" would lead to "a patchwork system where constitutional rights are available in some states but not in others"); *cf.* Shapiro v. Thompson, 394 U.S. 618, 627 (1969) (holding that minimum residency requirements for public welfare benefits "create two classes of needy resident families" and violate equal protection with respect to the right to travel).

[30] *Doe*, 410 U.S. at 200.

[31] 1 WILLIAM BLACKSTONE, COMMENTARIES *130, *cited in* Civil Rights Cases, 109 U.S. 3, 39 (1883) (Harlan, J., dissenting).

no less an originalist than Justice Clarence Thomas has embraced this definition, arguing that the term "liberty" in the Fourteenth Amendment fundamentally connotes nothing more than "freedom from physical restraint."[32] But this concept of liberty–while considerably less expansive than the modern notion of liberty as encompassing the right to privacy and decision-making autonomy[33]—is not necessarily a crabbed or archaic one: a concept of liberty grounded in freedom of movement may also support a broad conception of reproductive liberty as intimately related to women's right to travel, to cross state borders while retaining the appurtenances of citizenship, and to societal mobility.

Indeed, the liberty of movement, broadly understood, is an essential aspect of reproductive liberty. Liberty of bodily movement is arguably the most fundamental attribute of citizenship, just as a fundamental attribute of slavery consists in the inability to leave captivity, to choose where one will enter or stay.[34] Likewise, involuntary parenthood constrains women's options. Pregnancy may in some cases literally constrain women's physical movement; but more importantly, parenthood may limit women's social and economic mobility—which also often involves geographic mobility.[35] At the same time, the need to access abortion may force women to engage in unwanted travel, perhaps even out of state, as the Supreme Court recognized in *Whole Woman's Health v. Hellerstedt*, in striking down the Texas law that would have closed nearly all of Texas's abortion clinics and left broad swaths of the state with no abortion access at all.[36]

The constitutional right to travel has itself long been intertwined with racial and gender equality. *Dred Scott v. Sandford*, for example, involved the question whether an American slave became free by traveling to territory in which slavery was not recognized, thus garnering

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[32] Obergefell v. Hodges, 135 S. Ct. 2584, 2633 (2015) (Thomas, J. dissenting); *see also* Raoul Berger, *Liberty and the Constitution*, 29 GA. L. REV. 585, 587-88 (1995); Charles Warren, *The New "Liberty" Under the Fourteenth Amendment*, 39 HARV. L. REV. 431, 444–45 (1926).

[33] The classic case, of course, is *Roe v. Wade*, 410 U.S. 113 (1973). *Id.* at 153.

[34] Of course, liberty of movement across state borders is also an essential aspect of American federalism.

[35] *See, e.g.*, Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. HEALTH 407 (2018).

[36] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2318 (2016), *as revised* (June 27, 2016).

the benefits of that legal regime.[37] This question was situated within a broader political, legal, and moral battle over the power of states to exercise extraterritorial power and impose their views on slavery—whether pro or con—on citizens of other states that might disagree.[38] Of course, the Supreme Court's denial of Scott's citizenship meant that he could not benefit from the anti-slavery regime of other states; it thus denied him, among many other things, a meaningful right to travel and to move about freely at will. In *Shapiro v. Thompson*, the Supreme Court struck down state laws imposing minimum residency requirements on indigent people, which were adopted with the specific goal of deterring poor families from moving to those states.[39] The Court noted that "the nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement."[40] And in *Saenz v. Roe*,[41] the U.S. Supreme Court vindicated the right of several women who were fleeing to California in order to get away from abusive relationships in their home states to avail themselves of public benefits under California law on the same terms as other citizens of the state.[42] In all of these cases, claimants asserted a right to equality in the form of a claim of equal citizenship that was intimately connected to the right to travel—that is, a right to avail themselves of certain fundamental privileges regardless of their states of residence.

This basic framework, connecting the Fourteenth Amendment's guarantees of liberty, equality, and fundamental rights to the right to travel and to freedom of movement more generally, represents both a lost history and a way forward in challenging spatial regulation of abortion. As Parts II through IV demonstrate, governments control women's bodies and subject them to second-class citizenship through the control of borders and physical spaces. This form of state control often goes unrecognized for what it is, because spatial regulation has a tendency to appear more neutral, or less the result of official mandates,

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[37] Dred Scott v. Sandford, 60 U.S. 393, 394 (1857).
[38] *See generally* Kreimer, *Law of Choice*, *supra* note 13, at 466-69.
[39] Shapiro v. Thompson, 394 U.S. 618, 627-29 (1969).
[40] *Id.* at 629.
[41] 526 U.S. 489 (1999).
[42] *Saenz*, 526 U.S. at 494. Susan Frelich Appleton points out this fact about the plaintiffs in *Gender, Abortion, and Travel*, *supra* note 13, at 674.

than it actually is. For this reason, as Part V argues, a new conception of liberty and equal citizenship is urgently needed.

II. Regulation of the Spaces Where Abortions Take Place: Enforcing the Physical and Doctrinal Isolation of Abortion

This Part begins with an overview of facility regulations, which are the most obvious and straightforward example of spatial regulation of abortion. Such laws impose particular requirements on the places where abortions may be performed. They usually have the widely recognized and expected effect of making abortion more expensive and more difficult to provide and receive, and as a result, advocates have challenged them as imposing an undue burden on abortion access. As discussed below in Part I.B., they also have less obvious effects that make them a particularly attractive form of legislation for lawmakers seeking to restrict access to abortion.

A. The Law and Policy of Abortion Facility Regulation

Facility regulations have a lengthy pedigree, but they seem to have become particularly popular in more recent years among states seeking to restrict abortion access. *Roe v. Wade* had left open the possibility that laws regulating the places where abortions are performed would be found constitutional.[43] And indeed, abortion opponents began introducing such laws as early as the 1970s.[44] But they did not appear to gain steam until the 1990s and 2000s, perhaps due to those groups' perception that *Planned Parenthood v. Casey*, in 1992, had further opened the door to them.[45] In *Casey*, the Supreme Court held that abortion restrictions would no longer be subject to strict scrutiny and instead would pass muster if they did not constitute an "undue burden" on

[43] Roe v. Wade, 410 U.S. 113, 163 (1973) ("[A] State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.")
[44] *See, e.g.*, Ziegler, *Liberty*, at 441.
[45] *Id.* at 442.

abortion access.[46] *Casey* thus introduced a notably amorphous legal standard that seemed to invite envelope-pushing by states seeking to restrict abortion. Facility regulations also fit well with anti-abortion groups' strategy of inducing incremental change in abortion law rather than seeking the wholesale overruling of *Roe v. Wade*, and they allowed those groups to present themselves as interested in protecting the welfare of women.[47] Thus, a confluence of historical and political factors, gathering over at least two decades, led advocacy groups to push for, and anti-abortion legislators in many states to adopt, an array of laws that targeted abortion clinics, rather than the abortion procedure itself.

Some such laws take the form of physical plant specifications pertaining to corridor width, and the size of procedure rooms.[48] Others include requirements that providers of abortion outside the hospital setting must have admitting privileges at a hospital or an agreement or affiliation with a hospital or provider with admitting privileges.[49] Some of these laws even apply to facilities where only non-surgical abortions—early abortions completed with the use of medications only—are offered.[50] Often, these requirements are expensive to comply with, and in some places it can be impossible for an abortion clinic to find a hospital or a non-abortion-providing physician willing to enter into an affiliation with it.[51]

Though ostensibly aimed at ensuring the safety of the abortion procedure, such regulations often have minimal safety benefits, which are largely outweighed by their significant burden on abortion access.[52] For example, a requirement that a physician performing abortions in a clinic maintain hospital admitting privileges may turn out to be impossible to comply with in many places. The term "admitting privileges" refers to a doctor's authority, granted by the hospital, to admit patients to stay overnight at that hospital and to treat them there; generally, a hospital treats the grant of admitting privileges as equivalent

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[46] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992).
[47] Ziegler, *Liberty*, at 442.
[48] *See, e.g.*, Alan Guttmacher Inst., *supra* note 4.
[49] *Id.*
[50] Nineteen states currently apply such requirements in facilities where medication-only abortions are performed. *Id.*
[51] *See, e.g.*, Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2312 (2016); Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908, 916-17 (7th Cir. 2015).
[52] *Whole Woman's Health*, 136 S. Ct at 2310-11.

to making a doctor a member of its staff.[53] Because abortions are provided primarily in non-hospital settings, however, an abortion provider is unlikely to have a relationship with a hospital unless she also treats other kinds of patients. Moreover, some hospitals require a certain number of patient admissions in order for a physician to receive and maintain privileges; because abortion is a safe, minor surgical procedure generally performed in an outpatient setting, it rarely results in hospital admission (which would only be required in the case of a relatively serious complication).[54] Finally, hospitals may decline to extend admitting privileges to a physician for any reason, including reasons unrelated to clinical competence, and many do so either because their religious affiliation does not permit them to affiliate with an abortion provider, or simply because they wish to avoid the controversy associated with doing so.[55]

Litigation concerning facility regulations has been particularly active in recent years as courts have worked to apply the "undue burden" framework in this context. In 2016, in *Whole Woman's Health v. Hellerstedt*, the U.S. Supreme Court considered the constitutionality of two different abortion facility regulations adopted by the state of Texas: a requirement that abortion providers have admitting privileges at a local hospital and a requirement that abortion clinics conform to expensive physical plant requirements so as to qualify as ambulatory surgical centers (ASCs), without the opportunity for waiver or for grandfathering of existing clinics.[56] In articulating the legal standard it would apply, the Court in *Whole Woman's Health* claimed that "*Casey* … requires that courts consider

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[53] *Id.*. at 2312; *Schimel*, 806 F.3d at 909.

[54] *Whole Woman's Health*, 136 S. Ct. at 2312-13; *Schimel*, 806 F. 3d at 916-97.

[55] *Whole Woman's Health*, 136 S. Ct. at 2312-13; EMW Women's Surgical Ctr., P.S.C. v. Glisson, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *4 (W.D. Ky. Sept. 28, 2018) (noting that the termination of a hospital's transfer agreement with Planned Parenthood was partly due to "public controversy," as well as the expressed view of the Archdiocese of Louisville) , *appeal docketed,* 18-6161 (6th Cir. Nov. 5, 2018); *see generally* Mauer v. Highland Park Hosp. Found., 90 Ill. App. 2d 409, 412–13 (Ill. App. Ct. 1967) ("It is a well-settled rule that a private hospital has the right to refuse to appoint a physician or surgeon to its medical staff, and this refusal is not subject to judicial review; the decision of the hospital authorities in such matters is final." (citing State ex rel. Sams v. Ohio Valley General Hospital Association, 140 S.E.2d 457, 462 (W. Va. 1965); Schulman v. Washington Hospital Center, 222 F. Supp. 59, 63 (D.D.C. 1963); Khoury v. Community Memorial Hospital, Inc., 123 S.E.2d 533, 539 (Va. 1962); Manczur v. Southside Hospital, 183 N.Y.S.2d 960, 961 (1959); *and* Levin v. Sinai Hospital of Baltimore City, 46 A.2d 298, 301 (Md. 1946)).

[56] *Whole Woman's Health*, 136 S. Ct. at 2312-13.

the burdens a law imposes on abortion access together with the benefits those laws confer," necessitating a balancing of burdens against benefits to determine whether the burden on abortion access is "undue"—that is, unjustified by its benefits.[57]

The Court reviewed the extensive evidence presented in the trial court regarding the safety benefits of each law—which were found to be minimal or nonexistent[58]—and the corresponding burden on abortion access—which, in this case, meant the closure of about thirty-two of Texas's forty abortion clinics, requiring women in some parts of the state to travel over 400 miles roundtrip to obtain an abortion.[59] Balancing the negligible safety benefits against the significant burdens on abortion access, the Court held that the Texas regulations amounted to an "undue burden" on abortion and were therefore unconstitutional under the framework set forth in *Planned Parenthood v. Casey*.[60] Crucially, *Whole Woman's Health* explained that courts must consider the actual, on-the-ground burdens imposed by a particular abortion restriction and weigh them against any benefits that the law would bring.[61] If the actual, record-supported benefits of the law were outweighed by such real-life costs, the Court explained, the law's burden would be "undue."[62] Following its own advice, the Court in *Whole Woman's Health* demonstrated attentiveness to the particular burdens faced by rural women and to the problems of requiring women to seek care in overcrowded clinics due to increased demand for services.[63]

While litigation over facility regulations continued to play out in lower courts under the *Whole Woman's Health* balancing test, a differently composed Supreme Court had an opportunity to reconsider that test just four years later. In *June Medical Services v. Russo*, the Supreme Court struck down a Louisiana law requiring admitting privileges for abortion providers—a law that was "substantially identical" to the Texas law it held unconstitutional in *Whole Woman's Health*.[64] The law, if allowed to go into effect, would have closed two of Louisiana's three abortion clinics

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[57] *Id.* at 2309-10.
[58] *Id.* at 2311-12, 2315-16.
[59] *Id.* at 2301-02.
[60] *Id.* at 2300.
[61] *Id.* at 2309.
[62] *Id.* at 2313, 2318.
[63] *Id.* at 2302, 2318.
[64] June Med. Servs. L. L. C. v. Russo, 140 S. Ct. 2103, 2113 (2020) (plurality op.).

and left it with only one abortion-providing physician in the state.[65] However, because Justice Kennedy, who provided the fifth vote in the *Whole Woman's Health* majority, had been replaced by the more conservative Justice Kavanaugh, only four Justices from that original coalition remained on the Court. Chief Justice Roberts, who had dissented in *Whole Woman's Health*, nonetheless joined Justices Breyer, Ginsburg, Kagan, and Sotomayor in striking down the Louisiana law. In his separate concurrence to the four-Justice plurality opinion, Roberts asserted that "[t]he Louisiana law impose[d] a burden on access to abortion just as severe as that imposed by the Texas law, for the same reasons," and therefore stare decisis required the Court to declare it unconstitutional."[66] At the same time, he placed the *Whole Woman's Health* balancing test into doubt, insisting that "[n]othing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts."[67] Instead, Roberts insisted, courts should only look at the burden side of the equation—that is, they should only strike down a law if the burden it placed on abortion access was sufficiently substantial.[68]

In the context of facility regulations, the decision whether to engage in balancing of benefits and burdens can be dispositive. If the court focuses only on how substantially a law burdens abortion access, without comparing that burden to the benefits the law was supposed to advance, then courts will be more likely to uphold restrictions that have little to no actual medical benefits but impose a less severe burden than those at issue in *Whole Woman's Health* and *June Medical Services*, which threated to shutter the majority of clinics in the state. Thus, it is important for courts considering facility regulations to determine the significance of Chief Justice Roberts's separate opinion. Under the rule announced by the Supreme Court in *Marks v. United States*, "[w]hen a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds.'"[69]

In the wake of *June Medical*, lower courts evaluating facility regulations immediately split on the proper test to apply under the *Marks*

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[65] *Id.* at 2129.
[66] *Id.* at 2134 (Roberts, C.J., concurring).
[67] *Id.* at 2136.
[68] *Id.* at 2138-39.
[69] Marks v. United States, 430 U.S. 188, 193 (1977) (quoting Gregg v. Georgia, 428 U.S. 153, 169 n. 15 (1976) (opinion of Stewart, Powell, and Stevens, JJ.)).

rule. In *American College of Obstetricians & Gyncologists v. FDA*, a Maryland district court held that the balancing test survived *June Medical*, since the "common denominator" of the plurality and the concurring opinions was "that a 'substantial obstacle' based solely on consideration of burdens is *sufficient* to satisfy the undue burden standard, [but] not that it is *necessary*."[70] By contrast, the Eighth Circuit in *Hopkins v. Jegley* ordered the lower court to reconsider its decision to enjoin a series of Arkansas abortion restrictions under the *Whole Woman's Health* balancing test, holding that *June Medical Services* had eliminated that test and required consideration only of the burdens on abortion access imposed by a law.[71]

Not all facility regulations take the form of admitting privileges requirements, however; some have directly attempted to control the places where abortion clinics may locate. An Alabama law passed in 2017 limited the places within a state where abortion clinics were permitted to locate, prohibiting them to exist within 2,000 feet of a public elementary school.[72] Deploying the *Whole Woman's Health* balancing test, a federal

[70] Am. Coll. of Obstetricians & Gynecologists v. United States Food & Drug Admin., No. CV TDC-20-1320, 2020 WL 3960625, at *16 (D. Md. July 13, 2020).

[71] Hopkins v. Jegley, 968 F.3d 912, 916 (8th Cir. 2020). Even prior to *June Medical*, courts sometimes upheld the constitutionality of TRAP laws. For example, the U.S. District Court for the Eastern District of Arkansas enjoined a law requiring physicians that provide medication-only abortions to have a relationship with a physician who can admit patients to a hospital—a law that was similar in both purpose and effect to the Texas admitting privileges requirement struck down in *Whole Woman's Health*.[71] In fact, the district court applied the same balancing of benefits and burdens that the Court mandated in *Whole Woman's Health*. Planned Parenthood Ark. & E. Okla. v. Jegley, No. 4:15-cv-00784-KGB, 2016 WL 6211310, at *20 (E.D. Ark. Mar. 14, 2016). The district court had found that this restriction would leave Arkansas with only one abortion clinic, and medication-only abortion would become entirely unavailable in the state. *Id.* Nonetheless, on appeal, the Eighth Circuit held that the trial court's evaluation of the burdens on women was not specific enough, as there was insufficient evidence in the record of the number of women who would face an obstacle in accessing medication abortion in Arkansas. Planned Parenthood of Arkansas & E. Oklahoma v. Jegley, 864 F.3d 953, 959-60 (8th Cir. 2017), *cert. denied*, 138 S. Ct. 2573 (2018).

[72] ALA. CODE § 22-21-35. Similarly, a city in Tennessee passed a zoning restriction that had the effect of preventing any abortion clinic from locating within the city limits. FemHealth USA, Inc. v. City of Mount Juliet, No. 3:19-CV-01141, 2020 WL 2098234, at *3 (M.D. Tenn. May 1, 2020). The case was settled after a district court held the provision was likely unconstitutional. Andy Humbles, *Mt. Juliet to Pay $225K*

district court held that law to constitute an undue burden.[73] Although supposedly adopted to "minimize[e] disturbance in the educational environment" (from protestors outside the clinics) and to "support[] a parent's right to control his or her children's exposure to the subject of abortion," the court found that these interests were insufficient to justify the law's burdens.[74] There was no evidence of any disruption of the nearby schools and minimal evidence of injury to parents' interests, and the law would force the closure of two clinics in two major Alabama cities, which provided 70% of abortions in the state.[75] This would greatly increase delays and travel distances for many women in the state, and abortion after 15 weeks of pregnancy would become complete unavailable in Alabama.[76]

Laws regulating particular abortion methods are less obvious examples of facility regulation. Several states have adopted laws banning a particular method of abortion, known as dilation and evacuation, or "D&E."[77] This procedure is not only the most common method of second-trimester abortion, it is also the only procedure that can be performed in a freestanding clinic setting after approximately thirteen to sixteen weeks of pregnancy. Although other methods of abortion at this stage of pregnancy do exist, those procedures cannot generally be performed in a clinic setting, as opposed to a hospital.[78] And since hospitals do not perform a significant number of abortions as compared

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in Abortion Lawsuit Settlement; 'A Bitter Pill to Swallow,' City Attorney Says, TENNESSEAN (Sept. 15, 2020), https://www.tennessean.com/story/news/local/wilson/mt-juliet/2020/09/15/mt-juliet-pay-225-k-abortion-settlement-carafem-clinic/5802117002/. Such laws may be part of a still relatively marginal movement to create "sanctuary cities" where abortion is not permitted. *See, e.g.*, Dionne Searcey, *The Wall Some Texans Want to Build Against Abortion*, N.Y. TIMES (March 3, 2020), https://www.nytimes.com/2020/03/03/us/politics/texas-abortion-sanctuary-cities.html.

[73] *West Alabama Women's Ctr.*, 299 F. Supp. 3d 1244, 1248 (M.D. Ala. 2017).

[74] *Id.* at 1253.

[75] *Id.* at 1254-58, 64.

[76] *Id.* at 1261-64.

[77] Alan Guttmacher Inst., Bans on Specific Abortion Methods Used After the First Trimester (Aug.1, 2019), https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester.

[78] *See, e.g.*, W. Alabama Women's Ctr. v. Williamson, 900 F.3d 1310, 1321 (11th Cir. 2018).

to clinics,[79] a law outlawing a particular method of abortion like D&E can in reality function as a total ban on abortions after a particular stage of pregnancy. Since D&E is the only practicable method of abortion in clinics after a particular stage of pregnancy, and only freestanding clinics provide abortions in most states (for all intents and purposes), the only abortions available after a particular point in pregnancy are D&E abortions. Thus, even regulation of the methods of abortion are, ultimately, also facility regulations.

Similarly, some states have imposed spatial limitations on telemedicine for the medication-only method of abortion.[80] Currently, nineteen states require the provider of abortion medication to be in the physical presence of the woman receiving the drug, although many of those states have more relaxed standards for telemedicine outside the abortion context.[81] Only one such law has been held unconstitutional outside the context of the coronavirus pandemic.[82] As in the other cases discussed above, the court in that case weighed the negligible-to-nonexistent health and safety benefits of the law against the severe reduction in abortion access caused by potentially extreme travel distances in the state, coupled with a 24-hour waiting period law.[83]

B. Implications of Facility Regulations

In order to understand the current impact of facility regulations on abortion availability and on abortion jurisprudence more generally, it is important to understand how abortion services are distributed in the

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[79] *See, e.g.*, *id.* (stating that "99.6% of abortions in Alabama occur in outpatient clinics"); Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 FAMILY PLANNING PERSP. 246, 246 (1991); *infra* text accompanying notes ___.

[80] *See, e.g.*, IOWA ADMIN. CODE R. 653—13.10; W. VA. CODE ANN. § 30-14-12d (West).

[81] Alan Guttmacher Institute, *State Laws and Policies: Medication Abortion*, https://www.guttmacher.org/state-policy/explore/medication-abortion (Oct. 1, 2018); Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252, 269 (Iowa 2015).

[82] *Planned Parenthood of the Heartland*, 865 N.W.2d at 269; *see* Guttmacher Inst., *Medication Abortion* (indicating that eighteen states ban telemedicine for abortion, but only one such law has been enjoined), https://www.guttmacher.org/state-policy/explore/medication-abortion. In *Am. Coll. of Obstetricians & Gynecol v. FDA*, a Maryland district court blocked enforcement of certain restrictions on the provision of medication abortion drugs by mail for the duration of the pandemic. No. CV TDC-20-1320, 2020 WL 3960625, at *1 (D. Md. July 13, 2020).

[83] *Id.* at 265-69.

U.S., and why they are distributed in this way. Approximately 95% of abortions are performed in freestanding clinics; only 5% are performed in hospitals or physicians' offices.[84] This geographical fact is not a mere historical accident; rather, it arose from an intentional decision by abortion-rights activists in the era leading up to *Roe* to prioritize provision of abortion services in non-hospital settings, with the goal of making abortion services more accessible and less expensive.[85] Clinics, which were visibly identified as women's health care providers, could provide abortions much less expensively than hospitals—much in the same way that freestanding birth control clinics increased access to contraception for lower-income women who were not able to obtain it discreetly from private physicians.[86]

Still, there was an initial expectation among abortion advocates that hospitals would continue to provide abortions and fill any gaps that clinics could not. This expectation turned out to be incorrect. In the year *Roe* was decided, about 18% (1064 of 6000) non-Catholic hospitals in the U.S. offered abortions; by 1981, that percentage shrank significantly, to approximately 6%.[87] Whereas about half of all abortions were performed in hospitals in 1973, by 1980 that figure was only 22%. As noted above, the percentage of abortions performed in hospitals today is almost negligible.

There are likely several reasons for the change. Many insurers do not provide coverage for abortion, and abortion cannot be subsidized by federal Medicaid funds.[88] However, it appears that hospital policies,

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[84] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability In the United States*, 2014, 49 PERSP. ON SEXUAL & REPROD. HEALTH 17, 20 (2017). Most nonhospital abortions are performed in specialized abortion clinics (59%), but a substantial proportion (36%) are performed in clinics that may also provide other services, such as family planning. *Id.*

[85] David J. Garrow, *Abortion Before and After* Roe v. Wade*: An Historical Perspective*, 62 ALB. L. REV. 833, 838 (1999). The free-standing clinic model is also discussed in DAVID J. GARROW, LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF *ROE V. WADE* 408-09, 456-57 (1994). For a general discussion of how abortion services were distributed in the years immediately before and after *Roe*, see GERALD N. ROSENBERG, THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? 189-201 (2d ed. 2008).

[86] Garrow, *Abortion*, *supra* note 85, at 834-35; 838.

[87] FAYE D. GINSBURG, CONTESTED LIVES: THE ABORTION DEBATE IN AN AMERICAN COMMUNITY 55 (1998).

[88] Alan Guttmacher Inst., Restricting Insurance Coverage of Abortion (Aug. 1, 2019), https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion; *see also* Stanley K. Henshaw, *The Accessibility of Abortion Services in the United*

driven by hostility on the part of hospital personnel, together with hospital boards' concerns about being seen as "abortion mills," drove hospitals to simply outsource this service in most circumstances. Indeed, one study from 1980 found that physicians' negative attitudes toward abortion were the primary driver of hospital policies in this area.[89]

These decisions about the provision of abortion services have had several significant long-term doctrinal and on-the-ground effects. For one thing, it has led to the spatial and doctrinal isolation of abortion from health care more generally. Just as one abortion-rights proponent, Dr. Robert Hall, predicted in the early 1970s, the relegation of abortion provision to clinics essentially let "organized medicine" off the hook for providing those services.[90] This led to the increased isolation of abortion providers, many of whose practices primarily or exclusive consisted of abortion provision.[91] It also made it easier to reduce abortion availability just by regulating the sorts of freestanding clinics where most abortions were performed, because they are easily singled out in statutory and regulatory frameworks.

In many states, facility regulations have severely affected the accessibility of abortion services. Most obviously, as explained above in Part II.A., onerous facility regulations can reduce the availability of abortion services because they can be too expensive or logistically impossible to comply with, especially since they require clinics to, in essence, gain the approval or at least the acquiescence of private parties (hospitals or non-abortion-providing physicians) in order to stay in operation.[92] Facility regulations have thus likely resulted in a significant reduction in abortion access in many states.

States, 23 FAM. PLANNING PERSP. 246, 246 (1991) ("In the United States, abortion services have been concentrated in clinics, initially because hospitals in many areas chose not to perform abortions when the procedure become legal in the early 1970s, and more recently because hospitals have been moving away from offering minor surgery in general.").

[89] Constance A. Nathanson & Marshall H. Becker, *Obstetricians' Attitudes and Hospital Abortion Services*, 12 FAM. PLANNING PERSP. 26, 26 (1980); *see also* ROSENBERG, *supra* note 85, at 189-95.

[90] Garrow, *Abortion*, *supra* note 85, at 839.

[91] *Id.* This point may be driven home by a comparative observation. In Canada, where legislative hostility to abortion is not as high as in the U.S., hospital abortions are more common. *See generally* Wendy V. Norman, et al., *Abortion Health Services in Canada: Results of a National Survey*, 62 CANADIAN FAMILY PHYSICIAN e209 (2016).

[92] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2302–03 (2016), as revised (June 27, 2016) (repeating the district court's findings that the cost complying with the Texas surgical-center requirement for existing abortion clinics would be

Importantly, these effects are not evenly distributed. Hospitals are more likely to be found in urban areas, as are abortion clinics. This state of affairs makes it more difficult for clinics to operate in rural settings and for rural women, many of whom are also poor, to access abortion.[93] Indeed, one recent study documents "substantial and persistent spatial disparities in access to abortion" in the U.S., such that many women—those in urban areas—live relatively short distances from an abortion provider, but a substantial minority—rural women—may live over fifty or even one hundred miles from any provider.[94] As discussed in more detail in Part III, the impact is so extreme in some cases that it threatens to leave entire states without a single abortion provider and to force women to cross state lines in order to access services. Moreover, this spatial inequality aggravates other forms of inequality, such as socioeconomic inequality, which makes travel substantially more difficult for poor women, who are less likely to be able to afford child care, time off work, and other expenses such as overnight lodging that may be necessitated by state laws requiring two trips to an abortion provider.

More broadly, facility regulations mean that the facts on the ground relevant to the burden imposed by particular abortion restrictions—which courts have found relevant to determining their constitutionality in the wake of *Whole Woman's Health*—will differ from state to state and within a particular state.[95] The admitting-privileges cases

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approximately 1-1.5 million dollars or more; that some clinics would be altogether unable to comply due to the constraints of the physical size of their locations; and that constructing a new, compliant clinic would likely cost 3 million dollars or more).

[93] Pruitt, *Gender, Geography & Rural Justice*, *supra* note 13, at 360-61. At the same time, this uneven geographical distribution of abortion services has led some to suggest that abortion providers "target" urban poor and minority neighborhoods. *See, e.g.* https://www.lifeissues.org/2017/02/investigation-planned-parenthood-speeds-targeting-minorities/.

[94] Jonathan M. Bearak, Kristen Lagasse Burke & Rachel K. Jones, *Disparities and Change over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 LANCET PUBLIC HEALTH e493, e495, e499 (2017). Note that, although almost all of the states in which travel distances increased also adopted abortion restrictions and suffered declines in the number of clinics, *id.* at e499, the study did not examine causal factors; it therefore does not confirm that restrictive abortion laws cause such access issues.

[95] *See* Mary Ziegler, *Rethinking an Undue Burden:* Whole Woman's Health*'s New Approach to Fundamental Rights*, 85 TENN. L. REV. 461, 491 (2018) ("*Whole Woman's Health* announces a test centered much more on the facts of how a law affects the exercise of a right in the real world."); Linda Greenhouse & Reva B. Siegel, *The*

from the Eighth Circuit and Fifth Circuit, discussed above, present one example of how facts on the ground can make a meaningful difference in courts' adjudication of nearly identical laws.[96] As another example, in a case challenging restrictions on the provision of medication abortion, advocates note that more than half of all women in Maine, which is the most rural state in the U.S.—live in counties without surgical abortion providers—suggesting that that this fact might weigh against the constitutionality of restrictions that would pass muster in another state.[97] Thus, the place- and context-sensitive attention to the realities of abortion access suggested by *Whole Woman's Health* could help ensure that the abortion right is meaningfully available, rather than just an abstraction. But at the same time, it ensures significant geographic variation in both the real scope of the constitutional right to privacy and in how Supreme Court doctrine is understood and applied.

Beyond these impacts on abortion access at both the state and sub-state level, facility regulation has had far-reaching effects on abortion rights doctrine itself. Though a product of the state's power to regulate medicine, facility regulation has ironically both resulted from and reinforced the legal and cultural isolation of abortion from health care in general. For example, it has likely helped to stigmatize abortion and abortion providers—thus making it easier to regulate abortion in ways that do not affect other, similarly situated medical services and reducing the likelihood that a political coalition of physicians and health care professionals would rally behind abortion providers when they are so targeted.[98] By continuing to ensure that abortion services are primarily

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Difference A Whole Woman Makes: Protection for the Abortion Right After Whole Woman's Health, 126 YALE L.J. FORUM 149, 161-62 (2016) ("In identifying the burdens imposed by the Texas law, the Court describes how enforcing the law would transform women's experience of abortion, and treats these changes in the conditions of access as constitutionally cognizable harms to women"); *see also* Lisa R. Pruitt, *Toward A Feminist Theory of the Rural*, 2007 UTAH L. REV. 421, 458 (2007).

[96] *Supra* text accompanying notes **Error! Bookmark not defined.**-**Error! Bookmark not defined.**.

[97] Complaint, *Jenkins v. Almay*, paras. 111-13 (D. Me. Sept. 20, 2017) (citing U.S. Census Bureau, *Maine: 2010 Population and Housing Unit Counts* 2 (2010), https://www2.census.gov/library/publications/cen2010/cph-2-21.pdf; Press Release, U.S. Census Bureau, Growth in Urban Population Outpaces Rest of Nation , Census Bureau Reports (Mar. 26, 2012), http://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html).

[98] Perhaps this differential form of regulation has also contributed to the unique and somewhat *sui generis* constitutional jurisprudence surrounding abortion, with its unique doctrinal tests and terminology. *See, e.g.*, Planned Parenthood of Se. Pa. v. Casey, 505

provided in specialized clinics outside of mainstream medical spaces, it has made abortion clinics and abortion doctors easier to target for harassment and violence by anti-abortion activists.[99] This targeting in turn creates an additional barrier and burden, on top of the problem of travel distance, for women seeking access to abortion services.

At the same time, legal regulation of abortion-providing facilities entrenches their legal designation as medical or even "surgical" spaces, to the exclusion of other sites where abortions may take place.[100] Facility regulations channel the performance of surgical abortions and even medication abortions into abortion clinics, even though the latter, at least, can be safely performed in other settings such as the woman's home.[101] Certainly, there is no need for medication abortions to be performed in ambulatory *surgical* centers. In fact, even most so-called "surgical" first-trimester abortions are arguably not even surgical procedures, since they do not require cutting the skin and do not involve a sterile opening.[102] Indeed, the border between what is health care and what is something else—self-care, perhaps—is not at all an obvious or natural one. Long before abortion became heavily regulated and

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U.S. 833, 857 (1992) (describing *Roe* as *sui generis*, in the context of a discussion of substantive due process doctrine); B. Jessie Hill, *The First Amendment and the Politics of Reproductive Health Care*, 50 WASH. U. J.L. & POL'Y 103, 103–04 (2016).

[99] *See generally* DAVID S. COHEN & KRYSTEN CONNON, LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM 6-7 (2015) (discussing "targeted harassment" of abortion providers and noting that harassment of clinic workers is an inexpensive and efficient way for anti-abortion activists to increase the costs of providing abortion services).

[100] In the words of Richard Ford, "the habit of organizing the administration of policy in any particular way is a choice. The practice of organizing activities as first and foremost occurring in a place defined by its borders is a habit, not a necessity." Richard Thompson Ford, *Law and Borders*, 64 ALA. L. REV. 123, 128 (2012).

[101] Elizabeth G. Raymond, et al., *Sixteen Years of Overregulation: Time to Unburden Mifeprex,* 376 NEW ENG. J. MED. 790, 792 (2017); Yael Swica, et al., *Acceptability of Home Use of Mifepristone for Medical Abortion*, 88 CONTRACEPTION 122, 125 (2013). Professor Yvonne Lindgren argues that prohibiting medication abortion in the home violates the right to privacy. Yvonne Lindgren, *The Doctor Requirement:* Griswold*, Privacy, and At-Home Reproductive Care*, 32 CONST. COMM. 341 (2017).

[102] *See, e.g.*, Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2316 (2016) ("[A]bortions typically involve either the administration of medicines or procedures performed through the natural opening of the birth canal, which is itself not sterile."). In fact, some courts have begun using the term "procedural abortion" rather than "surgical abortion," so as to emphasize that no actual surgery is involved. *See, e.g.*, Adams & Boyle, P.C. v. Slatery, 956 F.3d 913, 917 (6th Cir. 2020); In re Abbott, 954 F.3d 772, 781 n.15 (5th Cir. 2020).

medicalized, it was something women did on their own, with limited or no medical intervention;[103] one movement currently seeks to re-discover and vindicate the pre-*Roe*, pre-modern right of women to manage their own pregnancy terminations without fear of state criminal intervention.[104] Yet, the designation of abortion clinics as surgical spaces both minimizes access and increases state control over the procedure by entrenching its designation as a surgical procedure, subject to the state's police power to regulate the practice of medicine.

The profound but under-appreciated way in which facility regulation shapes the abortion landscape reflects a deeper causal relationship between spatial regulation and moral regulation by the state. As the geographer Margo Huxley has explained, the governmental production and regulation of physical spaces performs numerous functions; such regulation not only controls or confines conduct, but also produces a particular "social and moral order."[105] Spatial regulation to promote the interests of health and safety, in particular, is often tied to notions of "moral and spiritual health" as well: consider the longstanding association of "slums" with both unhealthy conditions and amorality.[106] "If these diseased areas and their inhabitants can be cured and improved," the logic goes, "the body of the city, the social body, and the proper relations between its parts and processes will be restored to normal, healthy equilibrium."[107]

A similar logic seems to have driven the shift to widespread facility regulation with respect to abortion: legislatures seized on the

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[103] For a fascinating history, see Monica E. Eppinger, *The Health Exception*, 17 GEO. J. GENDER & L. 665, 683-87 (2016).

[104] SIA Legal Team, Roe*'s Unfinished Promise: Decriminalizing Abortion Once and for All* (2017), https://docs.wixstatic.com/ugd/aa251a_66c348049b5c4871a5c867d09cf9a994.pdf. Similarly, researchers have begun to study health care delivery outside of traditional health care settings, such as by training barbers to check blood pressure and make referrals or even provide prescription medications—both in order in increase access and to capitalize on the pre-existing relationship of trust—to great positive effect. Aaron E. Carroll, *What Barbershops Can Teach About Delivering Health Care*, N.Y. TIMES (May 21, 2018), https://www.nytimes.com/2018/05/21/upshot/what-barbershops-can-teach-about-delivering-health-care.html.

[105] Margo Huxley, *Geographies of Governmentality*, *in* SPACE, KNOWLEDGE AND POWER: FOUCAULT AND GEOGRAPHY 137, 144 (Stuart Elden & Jeremy W. Crampton, eds. 2007). Huxley's work explicitly draws upon and applies that of French historian and philosopher Michel Foucault.

[106] *Id.*

[107] *Id.* at 145.

horrendous conditions at the clinics operated by one criminal and deeply unscrupulous abortion provider, Kermit Gosnell, as a reason for regulating abortion-providing facilities.[108] There is thus a "causal logic" that endows spatial regulation with a moral valence. The moral goal is also not to make abortion safer—a goal that the Supreme Court has demonstrated to be pretextual—but rather to advance the social and moral aim of eliminating the practice of abortion within the state, as evidenced by Governors' statements upon signing the laws that focus not upon health and safety, but rather upon the impact on availability of abortion services in the state.[109] Yet spatial facility regulations effectively conceal the moral agenda behind the legislation by providing a health and safety rationale for the regulation. In similar fashion, the physical isolation of abortion clinics has caused, or aggravated, the legal and social isolation of abortion from health care more generally.

Finally, and perhaps most importantly, facility regulations conceal the role of the state in burdening abortion rights. There seems to be a causal relationship between the existence of onerous facility regulations and reduced abortion access, but the line of causality is not always obvious.[110] Instead, a number of factors play undetermined roles in aggravating the vulnerability of clinics to closure in the face of such regulations.[111] The reluctance of third-party hospitals to grant clinics the arrangements they require in order operate appears to be a factor external to state regulation, but it is a reality that legislators exploit as part of an intentional strategy to reduce abortion access. The legal rule, which does not appear to be aimed at advancing moral aims (such as reducing abortions), relies upon realities on the ground to achieve precisely those goals. Those realities include the concentration of hospitals in urban areas; the refusal of most hospitals to perform abortions, due in part to legal rules or industry norms preventing insurance coverage for the procedure in most circumstances; the widespread religious affiliation of

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[108] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2343-44 (2016), as revised (June 27, 2016) (Alito, J., dissenting) (noting Texas's facility regulation was "was one of many enacted by States in the wake of the Kermit Gosnell scandal"); Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908, 923–24 (7th Cir. 2015) (Manion, J., dissenting) (describing Gosnell's "shop of horrors" as the impetus for Wisconsin's admitting privileges requirement).

[109] *See infra* text accompanying notes 118-121.

[110] *See supra* note 94.

[111] *See* Michelle L. McGowan, Alison H. Norris & Danielle Bessett, *Care Churn—Why Keeping Clinic Doors Open Isn't Enough to Ensure Access to Abortion*, 383 NEW ENG. J. MED. 508 (2020).

hospitals; and the isolation of freestanding abortion providers from other health care providers. These realities are not generally taken into account when courts analyze the constitutionality of facility regulations, however—instead, they are seen as neutral, pre-existing, states of affairs unrelated to the legislation itself. For example, in one case, the Sixth Circuit Court of Appeals acknowledged the extensive difficulties experienced by one Ohio clinic in attempting to obtain a legally required transfer agreement with a local hospital.[112] One hospital simply declined to enter into such an agreement, and the other rescinded an agreement after objections from a member of the hospital's board who opposed abortion.[113] Yet the court found that the facility regulation was a "facially neutral" regulation and had no invalid purpose; these facts did not ultimately play a role in the court's analysis, which focused solely on the distance women would have to travel to obtain an abortion if the clinic were to shut down.[114]

Some courts and scholars have begun to recognize, however, that the geographical disparities that result from facility regulation are a direct result of state policies. In *Whole Woman's Health*, the Court recognized for the first time the disproportionate impact of facility regulations on poor and rural women and used this fact as a reason in support of its decision.[115] Similarly, scholars have described how physical location—one's neighborhood or zip code—functions as powerful predictor of life expectancy and determinant of health.[116] Sociologist Carolette Norwood has explicitly connected this reality to the history of segregation and official discrimination, which now manifest as "structural" violence—violence in the form of severe inequality in access to goods and services arising from underlying social and political arrangements that

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[112] Women's Med. Prof'l Corp. v. Baird, 438 F.3d 595, 599-600 (6th Cir. 2006).
[113] *Id.* at 599 & n.3.
[114] *Id.* at 607.
[115] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2302 (2016), as revised (June 27, 2016).
[116] *See, e.g.*, Virginia Commonwealth University Center on Society and Health, *Mapping Life Expectancy*, https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html; Garth Graham, MaryLynn Ostrowski & Alyse Sabina, Defeating the ZIP Code Health Paradigm: Data, Technology, and Collaboration Are Key, Health Affairs Blog (Aug. 6, 2015), https://www.healthaffairs.org/do/10.1377/hblog20150806.049730/full/.

disadvantage poorer citizens—and "spatial violence"—violence that is concentrated in a particular geographical space.[117]

III. Border Control: Zoning Out Abortion and Creating Reproductive Refugees

Spatial regulation of abortion extends beyond facility regulation. At times, abortion regulations drastically affect access to abortion within an entire state or even reach beyond state or national borders. First, facility regulations that close abortion clinics on a massive scale have threatened to leave entire states without an abortion provider. These laws appear to be the result of intentional efforts to make some states "abortion-free." Second, laws have been proposed or passed that regulate the ability of women under the age of eighteen to access abortion outside the borders of their state. Finally, the federal Government has taken steps to regulate the access of undocumented minors to abortion in the U.S. after crossing the Southern border. As discussed below, all of these instances of abortion-related "border control" highlight the relationship between liberty and citizenship and again demonstrate the effectiveness of spatial regulation in concealing the role of the state in enforcing or aggravating various forms of inequality.

A. The Relationship Between Spatial Abortion Restrictions and State and National Borders

As noted above, the ability to police borders is a fundamental attribute of sovereignty, just as the ability to travel and cross borders freely is a fundamental attribute of liberty, or self-sovereignty. For this reason, it should come as no surprise that state and national borders take on special significance in the struggle over the control of women's reproductive autonomy. This significance has manifested in various ways.

In some states, including Mississippi, Missouri, and Kentucky, facility regulations have come to the verge of shutting down all abortion clinics in the entire state—a result that, in each state, seemed to be the

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[117] Carolette R. Norwood, *Mapping the Intersections of Violence on Black Women's Sexual Health within the Jim Crow Geographies of Cincinnati Neighborhoods*, 39 FRONTIERS 97, 97-98 (2018).

very purpose of the regulations. Indeed, in Mississippi, elected officials clearly expressed their specific intent to this effect. Governor Phil Bryant, on vowing to sign a bill requiring abortion providers to have admitting privileges at a local hospital, stated, "I will continue to work to make Mississippi abortion-free."[118] The lieutenant governor of that state similarly quipped, shortly after the law's passage, that it "should effectively close the only abortion clinic in Mississippi."[119] Individual legislators made comments to the same effect.[120] When Texas passed S.B. 5—the facility regulation challenged in *Whole Woman's Health*—the state's lieutenant governor posted the following tweet, which made visible the geographic impact of the law on abortion availability:[121]

[118] Complaint, Jackson Women's Health Org. v. Currier, ¶ 19, No. 3:12-cv-00436 (filed June 27, 2012) (quoting Phil West, *Mississippi Senate Passes Abortion Regulation Bill*, The Commercial Appeal, April 4, 2012).
[119] *Id.* ¶ 18 (quoting Joe Sutton & Tom Watkins, *Mississippi Legislature Tightens Restrictions on Abortion Providers*, CNN Politics (April 4, 2012).
[120] *Id.* ¶¶ 21-22.
[121] David Dewhurst (@DavidHDewhurst), Twitter (June 19, 2013, 7:41 AM), https://twitter.com/davidhdewhurst/status/347363442497302528?lang=en.

In the case of Kentucky, while there were no such direct remarks, a pattern of arbitrary enforcement of the state's facility regulations strongly suggested a desire to shut down the state's last remaining abortion clinic.[122]

Thus, in some cases, states have attempted to force any women seeking abortion access to leave the state, creating "a patchwork system where constitutional rights are available in some states but not others,"[123] and making women into "reproductive refugees."[124] But courts have so far held that a regulation that would force the closure of a state's last abortion clinic constitutes an unconstitutional undue burden, at least when a sufficient health or safety-related justification is lacking.[125]

Other regulations have been passed or proposed that regulate extraterritorial access to abortion. In several successive sessions of Congress, for example, a bill has been proposed that would criminalize taking a minor across state lines to have an abortion and avoid a parental consent or parental notice requirement in the minor's home state. The proposed Child Custody Protection Act ("CCPA"), which has been introduced eight times since 1998, would criminalize the act of taking a minor across state lines for an abortion in order to avoid a parental-notice or parental-consent requirement in the minor's home state.[126] The Child Interstate Abortion Notification Act ("CIANA"), which has been introduced five times since 2006, would add a requirement that abortion providers notify the parents of all minors seeking abortions unless the minor has *not* traveled from another state *and* the abortion is being

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[122] EMW Women's Surgical Ctr., P.S.C. v. Glisson, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *2-3 (W.D. Ky. Sept. 28, 2018) (describing how, despite a facility regulation being in place for 19 years without any problems, the state began suddenly declining to renew a clinic's license for various technical reasons).

[123] *JWHO*, 760 F.3d at 455 (quoting district court opinion) (internal quotation marks omitted).

[124] Brief of Amici Curiae Law Professors Melissa Murray, I. Glenn Cohen and B. Jessie Hill in Support of Petitioners, Whole Woman's Health v. Hellerstedt, 2015 WL 9601563 (U.S.), 18-21 (2015).

[125] *EMW*, 2018 WL 6444391, at *28; Jackson Women's Health Org. v. Currier, 760 F.3d 448, 458 (5th Cir. 2014).

[126] S.32 113th Cong. (2013); *see also* H.R.3682, 105th Cong. (1998); H.R.1218, 106th Cong. (1999); S.661, 106th Cong. (1999); H.R.476, 107th Cong. (2002); S.403, 109th Cong. (2006); S.2543, 110th Cong. (2008); S.1179, 111th Cong. (2009); S.167, 112th Cong. (2011); S.32, 113th Cong. (2013).

provided in one of the twelve states that lack a parental involvement requirement.[127]

Although neither of these federal laws has yet been enacted, several states have laws that appear to restrict minors' travel for abortion. For example, a 2005 Missouri law creates a civil cause of action for helping a minor to obtain an abortion without parental or judicial consent, which would presumably affect adults assisting minors with inter- or even intrastate travel.[128] This law has been upheld against challenges on First Amendment, Due Process, Commerce Clause, and right-to-travel grounds.[129] Other states restrict the venue where minors can apply for a judicial bypass—for example, to their county of residence or an adjoining county.[130] Read literally, such laws would mean that out-of-state minors generally cannot seek a judicial bypass and therefore cannot get an abortion in the state without parental consent.[131]

Finally, abortion restrictions have interacted even with national borders. In September 2017, an unaccompanied 17-year-old girl crossed the southern U.S. border into Texas, where she was taken into U.S.

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[127] Both laws contain exceptions for minors who have already received judicial permission to bypass the parental-involvement requirement (a "judicial bypass"), and for medical emergencies. S.369, 113th Cong. (2013); *see also* H.R. 748, 109th Cong. (2006); S.403, 109th Cong. (2006); H.R. 1063, 100th Cong. (2007); H.R. 634, 111th Cong. (2009); H.R. 2299, 112th Cong. (2011); S.1241, 112th Cong. (2011); H.R. 732, 113th Cong. (2013); S. 369, 113th Cong. (2013). For a discussion and defense of the CCPA and CIANA, see Teresa Stanton Collett, *Transporting Minors for Immoral Purposes: The Case for the Child Custody Protection Act & the Child Interstate Abortion Notification Act*, 16 HEALTH MATRIX 107 (2006). For a list of the states that currently have parental-involvement requirements, see NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides?: The Status of Women's Reproductive Rights in the United States* 24 (26th ed. 2017), https://www.prochoiceamerica.org/wp-content/uploads/2017/01/WhoDecides2017-DigitalEdition3.pdf.

[128] MO. ANN. STAT. § 188.250 (West); *see also* IND. CODE § 16–34–2–4.2(c).

[129] Planned Parenthood of Kansas v. Nixon, 220 S.W.3d 732, 735 (Mo. 2007) (holding the law constitutional). *But see* Planned Parenthood of Indiana & Kentucky, Inc. v. Comm'r, Indiana State Dep't of Health, 258 F. Supp. 3d 929, 952 (S.D. Ind. 2017) (issuing a preliminary injunction against a similar law in Indiana), *aff'd*, 937 F.3d 973 (7th Cir. 2019).

[130] *See, e.g.*, FLA. STAT. ANN. § 390.01114(a) (West); IND. CODE 35–1–58.5–2.5(b) (repealed).

[131] However, courts have often construed such venue restrictions not to limit the places where out-of-state minors can seek abortions, to avoid constitutional questions. Womancare of Orlando, Inc. v. Agwunobi, 448 F. Supp. 2d 1293, 1306 (N.D. Fla. 2005); Indiana Planned Parenthood Affiliates Ass'n, Inc. v. Pearson, 716 F.2d 1127, 1142 (7th Cir. 1983).

custody and placed in a shelter run by the Office of Refugee Resettlement (ORR).[132] There, the minor, described in the pleadings and cases as J.D. (for "Jane Doe"), learned she was pregnant, and she wished to terminate the pregnancy.[133] She successfully followed the procedures prescribed by Texas law for obtaining an abortion without notifying her parents and, with the help of a guardian ad litem, was able to arrange for private financing and transportation for the procedure.[134] Before she could obtain an abortion, however, ORR officials blocked J.D.'s travel to the clinic, telling her she could get the procedure only if she left ORR custody by being placed with a sponsor; alternately, if she did not want to be forced by U.S. officials to carry her pregnancy to term, she could agree to "voluntarily self-deport to her home country," where abortion is not, however, legal.[135] Thus, although as a "person" present within the U.S. J.D. unquestionably possessed a constitutional right to terminate her pregnancy while in the U.S.,[136] the federal Government was able to assert arbitrary authority over her reproductive choices and bodily integrity simply by virtue of her geographic situation—her physical presence within ORR custody, which itself was a result of her having crossed a national border. The Government's position was an assertion of complete authority—"an absolute veto"—over J.D.'s pregnancy, which could only be avoided by leaving the sovereign space controlled by the United States.[137] And indeed, J.D. was not the only minor to be handled in this manner—her treatment reflected a general policy of the ORR with respect to unaccompanied minors; this policy has led to a class action suit to enjoin the practice.[138]

B. Implications of Abortion Restrictions Affecting State and National Borders

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[132] Garza v. Hargan, 304 F. Supp. 3d 145, 151 (D.D.C. 2018), *aff'd*, 925 F.3d 1291 (D.C. Cir. 2019).
[133] *Id.*
[134] *Id.*
[135] *Id.*
[136] U.S. CONST. AMDT. V. Neither the courts nor the United States Government disputed that J.D. possessed this constitutional right. Garza v. Hargan, 874 F.3d 735, 737 (D.C. Cir. 2017) (Millett, J., concurring); Garza v. Hargan, 304 F. Supp. 3d 145, 162 n.5 (D.D.C. 2018), *aff'd in part, vacated in part, and remanded sub nom.* J.D. v. Azar, 925 F.3d 1291 (D.C. Cir. 2019).
[137] *Garza*, 304 F. Supp. 3d at 162.
[138] *Id.* at 150-51.

Abortion restrictions that interact with state and national borders have two major features. First, as with facility regulations, the legal mobilization of state and national borders in the context of abortion restrictions reinforces various forms of inequality while concealing the role of the state in creating and aggravating that inequality. A patchwork in which women in some states completely lack access to abortion creates a form of geographic inequality. Beyond geography, moreover, the inequality also plays out along the dimension of sex—since women are predominantly affected by the lack of access—but it also exploits and aggravates racial and economic inequality.[139] Some affected individuals may face intersecting forms of disadvantage—like J.D., whose racial and national identity, resulting in her crossing the Southern U.S. border, and whose status as a minor made her particularly vulnerable to the raw exercise of sovereignty by the U.S. Government not only over its borders but also over her body. Another stark instance of intersecting disadvantage created at least in part by spatial abortion regulation is demonstrated by the plight of undocumented immigrant women in the Rio Grande Valley in Texas who largely lack access to abortion care, in part because they cannot travel outside that region within Texas to an abortion provider without encountering a Border Patrol checkpoint. Only one clinic remained in the sprawling, nearly 5,000-square-mile Rio Grande Valley region at the time of the Supreme Court's decision in *Whole Woman's Health*.[140] Women living in that region would be forced to cross a national border (into Mexico) or a state border (into New Mexico) to access abortion services if the Supreme Court had allowed that final clinic to close. Moreover, even outside the border zone context, restrictions that increase travel burdens self-evidently fall harder on those women who are already financially insecure, since they can little afford

[139] Regarding the sex equality dimension, in considering the possibility of extraterritorial abortion regulation by states in a world without *Roe*, Susan Frelich Appleton speaks of "a gendered right to travel." Susan Frelich Appleton, *Gender, Abortion, and Travel After* Roe*'s End*, 51 St. Louis Univ. L.J. 655, 683 (2007).

[140] Whole Woman's Health v. Cole, 790 F.3d 563, 592-98 (5th Cir.), *modified*, 790 F.3d 598 (5th Cir. 2015), *rev'd and remanded sub nom.* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016), *as revised* (June 27, 2016); Kate Huddleston, *Border Checkpoints and Substantive Due Process: Abortion Rights in the Border Zone*, 125 YALE L.J. 1744, 1748 (2016); Madeline M. Gomez, *Intersections at the Border: Immigration Enforcement, Reproductive Oppression, and the Policing of Latina Bodies in the Rio Grande Valley*, 30 COLUM. J. GENDER & L. 84, 107-08 (2015).

the cost of travel itself—not to mention additional costs such as child care and lost wages.[141]

While state borders are significant insofar as they delimit the physical domain in which a state law applies—such as an abortion facility regulation, or a prohibition on traveling to another state for a minor's abortion—they are also treated as irrelevant and invisible. For example, in a challenge to Utah's 24-hour waiting period for abortion, the district court breezily dismissed the notion that the state of Utah is different from the state of Pennsylvania in any legally relevant way—a necessary showing for the plaintiffs, since the Supreme Court had upheld Pennsylvania's similar law.[142] The court acknowledged that Utah is larger than Pennsylvania and has far fewer urban areas but rejected as a "red herring" the argument that "the waiting period's burden is greater on rural women in Utah because they have farther to travel to get an abortion," since "[t]his travel burden is not a factor of state law."[143] Instead of recognizing the role of Utah law in burdening Utah women's access to abortion, the court treated such geographical facts as merely natural, inevitable, and irrelevant to the law's constitutionality. This mode of thinking appears to relieve the state of any responsibility for the law's effects in Utah.

Second, such abortion restrictions reinforce the importance of borders—state or national—in defining citizenship and controlling access to the benefits and protections thereof, even as states downplay the importance of those same borders, casting them as arbitrary and irrelevant. Thus, on the one hand, the state sometimes seeks to *avoid* boundary crossings, as in the case of the proposed CCPA and CIANA, as well as state laws that restrict travel and venue for minors seeking abortions. Extraterritorial criminalization of abortion—a possibility that can be contemplated in a post-*Roe* world—would similarly be aimed at keeping pregnant individuals from traveling outside the state for abortions.[144]

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[141] Women who seek abortions are disproportionately poor, and they are disproportionately black and Latina. Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of Abortion Patients In 2014 and Changes Since 2008* 5-7 (Alan Guttmacher Institute 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[142] Utah Women's Clinic, Inc. v. Leavitt, 844 F. Supp. 1482, 1490 (D. Utah 1994).

[143] *Utah Women's Clinic*, 844 F. Supp. at 1491 n.11.

[144] *See supra* note 13.

On the other hand, states sometimes seek to encourage or even force border crossings. For example, the federal government told J.D. that she could not exercise her right to access abortion within the boundaries of the United States but could choose to "self deport." Or, assuming a kind of "not in my backyard" posture, states have occasionally asserted as a defense to an undue-burden claim based on a dramatic reduction in abortion access that women can simply travel to adjoining states to access abortion, and that the clinics in those other states may even be closer to them than the in-state clinic or clinics in danger of closing.[145] This argument suggests that state borders are meaningless and arbitrary—that people can cross them at will, and that borders have no special significance for the exercise of constitutional rights, while at the same time states claim that their abortion facility regulations are vital to protecting the health and safety of the citizens within their borders.[146]

Generally, courts have rejected this defense, insisting that "state lines do matter,"[147] and citing the 1938 U.S. Supreme Court case *Missouri ex rel. Gaines v. Canada*[148] for the proposition that "a state cannot lean on its sovereign neighbors to provide protection of its citizens' federal constitutional rights."[149] *Gaines* was a case about racial equality. It involved a challenge to Missouri's policy of denying black students admission to its state-sponsored law school, the University of Missouri, but paying for them to attend an out-of-state school that would accept them.[150] Noting that "the obligation of the State to give the protection of equal laws can be performed only where its laws operate, that is, within its own jurisdiction" and that "[t]hat obligation is imposed by the

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[145] This claim was made in *JWHO*, 760 F.3d at 455; *EMW*, 2018 WL 6444391, at *25 ("Contending that the regulations do not impose an unconstitutional burden on a woman's access to abortion, Defendants point to the availability of abortion facilities in other states."); Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908, 918 (7th Cir. 2015); and Whole Woman's Health v. Cole, 790 F.3d 563, 596 (5th Cir. 2015).

[146] A related argument showing the arbitrary nature of state borders in abortion regulations is that laws that apply only in a single state, such as heightened informed consent requirements, may have "spillover" effects into other states, such as encouraging doctors to adopt those informed consent requirements even where they are not statutorily required to do so, in order to avoid civil lawsuits from patients. Katherine Shaw & Alex Stein, *Abortion, Informed Consent, and Regulatory Spillover*, 92 IND. L.J. 1, 6 (2016).

[147] *JWHO*, 760 F.3d at 455.

[148] 305 U.S. 337 (1938).

[149] *JWHO*, 760 F.3d at 457; *Schimel* at 919; *EMW* at *25.

[150] *Gaines*, 305 U.S. at 342.

Constitution upon the States severally as governmental entities,—each responsible for its own laws establishing the rights and duties of persons within its borders," the Court held the Missouri policy to be an unconstitutional violation of the Equal Protection Clause.[151] Indeed, the Court implied that this holding derived not just from the 14th Amendment, but federalism itself:

> It is an obligation the burden of which cannot be cast by one State upon another, and no State can be excused from performance by what another State may do or fail to do. That separate responsibility of each State within its own sphere is of the essence of statehood maintained under our dual system.[152]

Thus, the court in *Jackson Women's Health Organization v. Currier* rejected Mississippi's attempt to enforce a facility regulation that would shut down the state's last remaining abortion clinic, emphasizing the importance of state borders to the state's obligation to ensure citizens can exercise their constitutional rights.[153] At the same time, the dissenting judge in that case questioned whether "the [C]linic's closure would result directly from [the challenged law], as opposed to the independent decisions of local hospitals—non-state actors."[154]

This apparent contradiction—that state policies regulating abortion with respect to state and national borders alternately seeks to keep people who seek abortions within the state, and to kick them out, simultaneously reinforcing and minimizing the importance of those borders themselves—simply highlights the fact that the *ability to control* the borders and their implications is more important than whether borders are used to include or to exclude. The border itself as mobilized as a tool of control. As noted above, a fundamental and ancient characteristic of sovereignty is the ability to exercise power over individuals within a set of borders.[155] In the immigration context, Ayelet Schachar has referred to "the shifting border" of regulation, meaning

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[151] *Gaines*, 305 U.S. at 350.
[152] *Id.*
[153] *JWHO*, 760 F.3d at 457-58.
[154] *Id.* at 461.
[155] Pennoyer v. Neff, 95 U.S. 714, 722 (1877), *overruled in part by* Shaffer v. Heitner, 433 U.S. 186 (1977) ("[E]very State possesses exclusive jurisdiction and sovereignty over persons and property within its territory.").

that the line triggering enforcement of legal rules is movable and manipulable—"selectively utilized by…regulators to regain control over their crucial realm of responsibility, to determine who[m] to permit to enter, who[m] to remove, and who[m] to keep at bay."[156] And going a step further, geographer Mathew Coleman explains that what is really at issue is "social control" rather than "territorial control."[157] Borders in abortion regulation, like in immigration law, function more as a means of drawing distinctions among people on the bases of race, ethnicity, poverty, and other social characteristics, than as juridical boundaries.

IV. Spatial Regulation of Pregnant Bodies

Though less obvious in their relationship to borders, space, and geography than laws regulating abortion facilities and increasing travel burdens for women, another category of abortion restrictions may also be considered under the general rubric of spatial regulation. In this category are laws that regulate the internal geography of women's bodies.[158] These include laws that regulate the procedure sometimes referred to as "partial-birth abortion," as well as forced ultrasound requirements, which often require doctors not only to show women an ultrasound image of the fetus but also to provide a narrative explanation of it. These laws turn women's anatomy into a kind of geographical terrain.

Both types of laws became popular around the same time as the uptick in TRAP laws and were likely motivated by many of the same factors, such as a desire by abortion opponents to mobilize *Casey*'s doctrinal ambiguities in their favor and to demonstrate that abortion opponents were not anti-woman.[159] In addition, as further elaborated below, such laws exploit the notion of abortion as a medical procedure,

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[156] Ayelet Schachar, *The Shifting Border of Immigration Regulation*, 30 MICH. J. INT'L L. 809, 811 (2009); *see also id.* at 813 (noting a trend of "greater authority for national legislatures and regulatory agencies to develop new enforcement policies that manipulate the border—bleeding it into the interior or extending it beyond the territory's exteriors—whenever such maneuvers are beneficial to deter access by irregular migrants deemed inadmissible or deportable").

[157] Mathew Coleman, *Immigrant Il-Legality: Geopolitical and Legal Borders in the US, 1882—Present*, 17 GEOPOLITICS 402, 403 (2012).

[158] Mae Kuykendall has also recognized both abortion method bans and ultrasound mandates as regulations of "places" within a woman's body. *See* Kuykendall, *supra* note 13, at 789.

[159] *See* Ziegler, *Liberty*, *supra* note 3, at 457-58; Ziegler, *Substantial Uncertainty*, *supra* note 3, at 97-98. Thanks to Mary Ziegler for pointing out this connection.

drawing on the objective and respected rhetoric of science while mobilizing the potential for scientific uncertainty in support of abortion restrictions.[160]

A. Laws Mapping Women's Bodies

I have written elsewhere about the way in which the Supreme Court's rhetoric in *Gonzales v. Carhart*,[161] the 2007 "partial-birth" abortion case, rhetorically maps the terrain of women's reproductive anatomy.[162] I will summarize my argument briefly here, and then extend it to additional regulatory contexts. The essence of this argument is that legislatures have used spatial and geographic techniques to control women's bodies in ways that are similar to their use of spatial regulation or manipulation of state and local borders in relation to abortion restrictions.

1. Abortion Method Bans. Throughout the 1990s and 2000s, state legislatures passed laws banning an abortion method they referred to as "partial-birth abortion."[163] This legislation was followed, in 2003, by federal legislation aimed at essentially the same procedure.[164] Two different Supreme Court cases resulted from this legislative activity—*Stenberg v. Carhart*, in 2000, which struck down a Nebraska ban, and *Gonzales v. Carhart* in 2007, which upheld the federal ban.[165] Thus, after *Gonzales*, both federal law and some state laws mirroring the federal law ban this particular procedure.[166]

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[160] Ziegler, *Substantial Uncertainty*, *supra* note 3, at 97.

[161] 550 U.S. 124 (2007).

[162] B. Jessie Hill, *supra* note 13.

[163] Stenberg v. Carhart, 530 U.S. 914, 995 (2000) (Thomas, J., dissenting) (noting that, as of 2000, 28 states had banned the method known as "partial birth abortion"). The term "partial-birth abortion" is a political term, not a medically accurate one. It is, however, the popular terminology and the language used by the legislation banning the abortion method at issue. Hill, *supra* note 13, at 651 & n.12; *see also* Siegel, *Dignity*, supra note 9, at 1707.

[164] Partial–Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531.

[165] *Stenberg*, 530 U.S. at 922; *Gonzales*, 550 U.S. at 133.

[166] *See, e.g.*, ARK. CODE ANN. § 20-16-1202 to 1203; MICH. COMP. LAWS ANN. § 750.90h; N.H. REV. STAT. ANN. § 329:33 to 34; *see generally* Guttmacher Inst., *Bans of Specific Abortion Methods Used After the First Trimester*, https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester (July 1, 2019). A more recent spate of state laws goes further and bans the most common second-trimester abortion procedure, known as "dilation and evacuation" or "D&E."[166] Both *Stenberg* and *Gonzales* clearly implied that such a ban would be unconstitutional—and indeed, the *Gonzales* Court upheld the ban on "partial-birth abortion" partly because of the availability of D&E as an alternative

In the course of describing the proscribed "partial-birth" abortion procedure, both the legislation and the case law conduct a narrative mapping of the female body that demonstrates precisely the sort of border manipulation that takes place in more explicitly geographical forms of regulation. In particular, the Supreme Court engaged, in both cases, in a minute, graphic description of the abortion procedure known as intact dilation and evacuation in ways that construct the woman's body as a geographical space that not only permits but requires regulation and render the borders of her body profoundly manipulable.[167] These features of the "partial-birth abortion" cases mirror important features of the other spatial-regulation cases.

One form of border manipulation results from the Court's graphic descriptions of the procedure that takes place inside the woman's body. Here, for example, is one (edited but still lengthy) description of the banned abortion procedure by the *Gonzales* Court:

> In [the banned procedure, also known as intact D & E], the doctor extracts the fetus in a way conducive to pulling out its entire body, instead of ripping it apart. …
>
> Rotating the fetus as it is being pulled decreases the odds of dismemberment. A doctor also "may use forceps to grasp a fetal part, pull it down, and re-grasp the fetus at a higher level—sometimes using both his hand and a forceps—to exert traction to retrieve the fetus intact until the head is lodged in the [cervix]."
>
> …. In the usual intact D & E the fetus' head lodges in the cervix, and dilation is insufficient to allow it to pass. ….
>
> " 'At this point, the right-handed surgeon slides the fingers of the left [hand] along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down).
>
> " 'While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under

procedure. Gonzales v. Carhart, 550 U.S. 124, 147, 164 (2007); Stenberg v. Carhart, 530 U.S. 914, 938 (2000). No case involving a ban on ordinary D&E abortion has yet reached the Supreme Court.

[167] Hill, *supra* note 13, at 656-69.

> his middle finger until he feels it contact the base of the skull under the tip of his middle finger.
>
> " '[T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.
>
> " 'The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.' "[168]

This step-by-step detailing of this surgical procedure that occurs *inside* the woman's body rhetorically erases the borders of her body. The woman herself does not appear at all in this description; her body is without borders, if it exists at all, as the most intimate parts of her body are narratively on display as if they are in public view.[169] The procedure involves "dilation of *the cervix*," just as the fetal head becomes lodged in "*the cervix*."[170] The fetus "passes through" parts of the woman's anatomy and "is removed."[171] It is as though the Court is describing an act of violence that a doctor is committing against a fetus on open terrain, punctuated by "anatomical landmarks" that invoke the law's application.[172] "The female body is," simply, "a geographic space in which the drama plays out between the fetus and the doctor."[173]

But rather than saying that the woman is entirely invisible, it may be more accurate to say that she is present only as a victim, entirely lacking in agency. In the federal partial-birth abortion ban, as in virtually all modern abortion restrictions, the woman is exempted from prosecution—as if she has no agency and hence can bear no criminal responsibility.[174] Indeed, the woman's primary appearance in *Gonzales* is as an unknowing victim, suffering regret for an act she did not intend to commit. As Justice Kennedy opined, "It is self-evident that a mother

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[168] Gonzales v. Carhart, 550 U.S. at 137–38 (citations omitted).

[169] Indeed, the word "woman" appears only five times in the entire majority opinion, whereas the words "fetal" and "fetus" occur forty-one times and "doctor" thirty-one times. *Hill*, *supra* note 162, at 660 (citing *Gonzales*, 550 U.S. at 134-40).

[170] *Gonzales*, 550 U.S. at 137-39.

[171] *Id.* at 139-40.

[172] Hill, *supra* note 13, at 666-67.

[173] *Id.* at 661.

[174] 18 U.S.C. § 1531(e).

who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form."[175] The woman's verbal absence from the scene of the crime, so to speak, represents an absence of agency, which nonetheless does not prevent her from regretting what she "allowed" to be done to her. Indeed, the possibility of regret, along with the purportedly deceptive or coerced nature of the abortion act, ironically grounds the restriction on the abortion procedure in the name of protecting women's autonomy.[176]

But rather than simply disappearing, she is *made to* disappear through the total occupation of her body by a law that manages and controls it at an almost microscopic level. One might even think metaphorically here of the use of the term "disappear" as a transitive verb, as when agents of totalitarian governments seize individual citizens and make them disappear from society.[177] Both the statutory language of the ban and the Court's opinion in *Gonzales* re-draw the female anatomy. Perhaps most strikingly, both the statute and the majority opinion describe the banned procedure as one in which a portion of the fetus is "outside the body" of "the mother."[178] Apparently, the reason for this turn of phrase is that the prohibited abortion procedure involves passage of the fetus beyond the woman's cervix.[179] Yet, the cervix is not, in fact, the external border of the woman's body.[180] Nonetheless, the Court and

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[175] *Gonzales*, 550 U.S. at 159–60. Note that the fetus has a human body, but the woman does not.

[176] Professor Jeannie Suk argues that "[t]he harm envisioned in *Carhart* had the structure of trauma: an event whose meaning is not fully realized at the time of its occurrence, followed by a period of delay, latency, or ignorance, and then later symptoms that trace to the now-realized meaning of the earlier event." Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193, 1236 (2010). She explains that regret becomes trauma as it is "[r]efracted through the prism of coercion and non-consent," thus justifying restrictions on women's autonomy in the name of protecting their autonomy. *Id.* at 1251.

[177] Thanks to Marc Spindelman for pointing this out.

[178] 18 U.S.C. § 1531(b); *Gonzales*, 550 U.S. at 160.

[179] Gonzales 550 U.S. at 138 (explaining that, during the banned procedure, "the fetus' head lodges in the cervix, and dilation is insufficient to allow it to pass" until the physician performs another procedure that ultimately allows intact removal).

[180] "Though the Court seems strangely loath to acknowledge it, there is, technically, something between the woman's cervix and the outside world--namely, her vagina.

the legislature re-draw these boundaries at will; as in other spatial regulation contexts, the placement of borders, as well as their function and permeability, matters far less than the ability to manipulate them. The "line demarcating activity that can be criminalized from that which cannot…[is] not drawn at viability, as it always has been since *Roe v. Wade*, but rather at a place inside the woman's body."[181] It is precisely this ability to draw and redraw borders and to infuse them with significance or insignificance that is the mark of sovereignty and of social control.

The insistence that the abortion procedure occurs "outside the body" of the woman justifies its regulation. Suggesting that the fetus is killed outside the woman's body makes the procedure more akin to infanticide than to abortion. It also justifies the Court's and the legislature's insistently calling the pregnant woman a "mother"—as if she has already given birth.[182] This rhetoric rationalizes intrusive regulation by turning it into a public, criminal act, rather than a private surgical one.[183]

2. Ultrasound Laws. Mandatory ultrasound laws, like abortion method bans, have also been popular in state legislatures since the 1990s.[184] Ultrasound is an imaging technique that uses sound waves bouncing off of an object (in this case, the fetus) in order to create a moving, visual image of the fetus inside the uterus, in real time.[185] Like

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And indeed, the Court's opinion in *Stenberg*, like the statute at issue in that case, had described the fetus not as being outside the *body* but rather as being delivered 'into the vagina' prior to fetal demise." Hill, *supra* note 162, at 664–65 (citing *Stenberg v. Carhart*, 530 U.S. 914, 938-40 (2000) (quoting NEB. REV. STAT. ANN. § 28-326(9) (LexisNexis 1999)).

[181] Hill, *supra* note 13, at 667.

[182] *Id.* at 664. To be fair, the Court refers to the pregnant person as a "mother" in other cases as well, including in *Roe* itself. Roe v Wade, 410 U.S. 113, 150, 159-60 (1973).

[183] As I argue elsewhere:

> The Court's language … renders completely public even those body parts one might think of as profoundly private….[T]he law, not the woman herself, controls …the divide between what is inside and outside the body, between what is private and what is publicly exposed. If the Court constructs her vagina as somehow "outside the body," and if her cervix and uterus become, generically, "the cervix" and "the uterus," then they cannot belong to her in the sense that our private bodies belong to us.

Id. at 668–69 (footnotes omitted).

[184] Guttmacher Inst., *Requirements for Ultrasound*, https://www.guttmacher.org/state-policy/explore/requirements-ultrasound (July 1, 2019).

[185] F. GARY CUNNINGHAM, *ET AL*., WILLIAMS OBSTETRICS 182 (25th ed. 2018) ("The real-time image on the ultrasound screen is produced by sound waves that are

the Supreme Court's narrative description of the "partial-birth" abortion procedure in *Gonzales*, laws requiring ultrasound imagery of the fetus to be displayed prior to an abortion make external and visible that which is internal and private, and they similarly turn the woman herself into a passive background or geographic space rather than a fully human agent.

Mandatory ultrasound laws take various, more or less coercive, forms. Some states require abortion providers to perform an ultrasound before an abortion—which has become a common medical practice in any case—and a majority of those states also require the provider to offer the woman an opportunity to view the ultrasound image.[186] A handful of states go further and require that the provider offer a narrative description of the visual image, which includes pointing out the fetus's or embryo's location, making sure the fetal heartbeat is audible, and noting the presence of limbs and organs.[187] As Carol Sanger has observed, such laws not only require women, for no medical reason, to view a particular image that they may or may not wish to see, but they also require women "to offer up the content of their bodies in the form of an image for inspection before the law permits them to end a pregnancy."[188] In other words, these laws not only coerce viewing and listening to a state-mandated "message," but they also "coerce[]

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reflected back from fluid and tissue interfaces of the fetus, amnionic fluid, and placenta.").

[186] Guttmacher Inst., supra note 184; *see also* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA 120 (2017) ("To be sure, many doctors now administer ultrasound routinely before an abortion even without legal dictate.").

[187] For example, Kentucky's mandatory ultrasound law requires performance of an ultrasound before an abortion, as well as "a simultaneous explanation of what the ultrasound is depicting, which shall include the presence and location of the unborn child within the uterus and the number of unborn children depicted," display of the image so that the woman can see it, and auscultation of "the fetal heartbeat of the unborn child so that the pregnant woman may hear the heartbeat if the heartbeat is audible." If she so chooses, the patient may avert her eyes or request that the heartbeat volume be turned off. KY. REV. STAT. ANN. § 311.727 (West); *see also, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 171.012 (West) (requiring abortion provider to perform an ultrasound ("sonogram") and give, "in a manner understandable to a layperson, a verbal explanation of the results of the sonogram images, including a medical description of the dimensions of the embryo or fetus, the presence of cardiac activity, and the presence of external members and internal organs").

[188] SANGER, supra note 186, at 111. Proponents of such laws argue that there is a medical purpose for them, in that they ensure fully informed consent to the abortion procedure. *Id.* at 110.

production" of the message itself by the woman.[189] And the message that is coerced is a sort of "map" of the woman's uterus, sometimes with key landmarks demarcated; the main difference is that the map is one that generally magnifies the object it represents, rather than shrinking it to a visually useful scale.[190] Thus, although justified as measures designed to ensure informed consent, in both their compelled-production aspect and their detailed narrative and visual mapping of the woman's own body, mandatory ultrasound laws diverge from more straightforward informed-consent requirements focusing on the risks and benefits of the procedure.

Like the Supreme Court's narrative descriptions of the partial-birth abortion procedure, mandatory ultrasound laws marginalize the woman herself. As Rosalind Pollack Petchesky has written, fetal imagery—by its nature—"represent[s] the fetus as primary and autonomous, the woman as absent or peripheral."[191] The fetus's body, in all its detail, is the focus of mandatory ultrasound laws; the woman becomes the mere physical backdrop for the image she is forced to view. The woman "now becomes the 'maternal environment,' the 'site' of the fetus, a passive spectator in her own pregnancy."[192] This passivity is further enforced by mandatory ultrasound laws which deprive the patient of the option to decline the imaging and may even, for all intents and purposes, force her to participate in an objectifying ritual—one that turns both the fetus and the woman's anatomy into objects that she must visually contemplate as if they are separate from herself.[193]

Similarly, the ultrasound requirement involves erasing the boundaries of the woman's body. "Obstetrical technologies of visualization…disrupt the very definition, as traditionally understood, of

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[189] *Id.* at 111.

[190] *E.g.*, *id.* at 121-22.

[191] Rosalind Pollack Petchesky, *Fetal Images: The Power of Visual Culture in the Politics of Reproduction*, 13 FEMINIST STUD. 263, 268 (1987).

[192] Petchesky, *supra* note 191, at 277 (quoting Ruth Hubbard, *Personal Courage Is Not Enough: Some Hazards of Childbearing in the 1980s*, in TEST TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? 331, 350 (Rita Arditti, Renate Duelli Klein & Shelli Minden, eds., 1984), and BARBARA KATZ ROTHMAN, THE TENTATIVE PREGNANCY: PRENATAL DIAGNOSIS AND THE FUTURE OF MOTHERHOOD 113-15 (1986)).

[193] Stuart v. Camnitz, 774 F.3d 238, 253 (4th Cir. 2014) (observing that, in order to avoid the display and recitation required by North Carolina's mandatory ultrasound law, a woman "must endure the embarrassing spectacle of averting her eyes and covering her ears while her physician—a person to whom she should be encouraged to listen—recites information to her").

'inside' and 'outside' a woman's body, of pregnancy as an 'interior' experience."[194] The image of the fetus displayed on a screen, outside the context of the woman's body, is meant to suggest it is *already* a (living, separate) baby, much as the language of *Gonzales* and the Federal Partial-Birth Abortion Ban Act imply that the birth has already occurred and the woman is already a mother.[195] Moreover, although ultrasound may be performed externally (abdominally) or internally (vaginally), some state ultrasound mandates essentially compel a vaginal probe—requiring the doctor, by law, to breach the borders of the woman's body.[196]

Finally, mandatory ultrasound laws, too, seem to call forth further regulation of women's bodies. Carol Sanger has emphasized that, although abortion is legal throughout the U.S., the shaming and physical intrusion inherent in the process "underscore[] for women that what they are about to do is wrong."[197] In creating a suggestion of fetal personhood, like the Court's language in *Gonzales*, they imply that what is about to occur is not an abortion but a murder.[198] Moreover, mandatory ultrasound bears a relationship to other forms of excessive, intrusive monitoring. Ultrasound creates a "panoptics of the womb"—a space of continual monitoring in the name of surveillance and regulation.[199] Such a space of continual monitoring enables constant regulation without active enforcement; it is a metaphor for the mechanism of the modern state, in which governmental power, particularly over individuals' bodies, is always felt, even if not itself visibly present.[200]

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[194] Petchesky, *supra* note 191, at 272.

[195] SANGER, supra note 186, at 119; *supra* text accompanying notes XXX.

[196] SANGER, supra note 186, at 125-26.

[197] SANGER, supra note 186, at 126. Or in Mae Kuykendall's words, such laws "expand the place within the body subject to regulation—sonograms and monitoring—and reduce the space available to female embodiment for receipt of services." Kuykendall, *supra* note 13, at 793.

[198] *See, e.g.*, Jessica Knouse, *Mandatory Ultrasounds and the Precession of Simulacra*, 54 SAN DIEGO L. REV. 117, 119–20 (2017) (arguing that ultrasound mandates "render fetuses 'children' and pregnant women their 'mothers'" and "privilege the imagined 'personhood' of the fetus over the pregnant woman's reality").

[199] Petchesky, *supra* note 191, at 277 (emphasis omitted). The term "panoptics" is derived from Michel Foucault's concept of the panopticon, a prison design invented by Jeremy Bentham, in which it is possible to observe each prisoner at all times without the prisoner knowing whether she is being watched. MICHEL FOUCAULT, DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON 200-03 (2d ed. 1995).

[200] *Cf.* Petchesky, *supra* note 191, at 269 ("Historically, photographic imagery has served …the uses of scientific rationality—as in medical diagnostics and record-

B. Implications of Laws Mapping Women's Bodies

Though they appear, at first blush, to be quite different from TRAP laws and other geographic restrictions, both mandatory ultrasound laws and bans on intact D&E function in much the same way as those other spatial regulations. They use the manipulation of boundaries as a form of control, inscribing or re-inscribing women's inequality while concealing the mechanism by which they do so. They rely on the apparent naturalness of particular boundaries—here, bodily ones—in order to advance a political agenda while assuming a posture of objectivity. And they use physical boundaries to define personhood, just as other spatial regulations use geographical boundaries to define and delimit citizenship.

Both kinds of laws rely upon seemingly objective perspectives: medical discourse in the case of *Gonzales* and medical imaging technology in the case of the ultrasound.[201] Yet this apparent objectivity in each case underlies a particular moral or ideological agenda. The clinical description of the so-called "partial-birth" procedure constructs the fetal demise as occurring partly "outside the body" of the woman—but does so only by manipulating the very border of that body and describing the female anatomy in a way that is, at the very least, open to question.[202] In this way, it subtly suggests that the doctor performing the procedure is engaged in a criminal act. Similarly, the display and narrative description of the fetal anatomy required by some ultrasound laws occurs through the use of a technology that makes the fetus appear autonomous and separate from the pregnant woman and essentially effaces the borders of her own body.[203] The artificiality of this impression goes unnoticed, however; one court, for example, insisted "[t]hat these medically accurate depictions are inherently truthful and non-misleading," calling them "the epitome of truthful, non-misleading information."[204] Women's internal

keeping—and the tools of bureaucratic rationality—in the political political record keeping and police surveillance of the state.").

[201] Petchesky points to "the visual apparatus's claim to be 'an unreasoning machine' that produces 'an unerring record,'" noting that "the French word for 'lens' is *l'objectif*." Petchesky, *supra* note 191, at 269.

[202] *See supra* note 180 and accompanying text.

[203] *See supra* text accompanying notes 191-196.

[204] Texas Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 577-78 (5th Cir. 2012); *see also* EMW Women's Surgical Ctr., P.S.C. v. Beshear, 920 F.3d 421, 429 (6th Cir. 2019) ([N]o one argues that the heartbeat, sonogram, or its description is false or misleading. We have previously held that similar information conveys objective medical facts").

geography, like the geography of state borders and freestanding abortion clinics, is taken for granted, yet always subject to manipulation and interpretation.

Indeed, the hand of the state is present but invisible in the drawing of this internal geography. Though driven by legislative mandate, the intrusive ultrasound examination may be carried out by any medical professional or ultrasound technician.[205] It is, in the context of mandatory ultrasound laws, "a machinery that assures dissymmetry, disequilibrium, difference. Consequently, it does not matter who exercises power. Any individual, taken almost at random, can operate the machine."[206] It thus may seem as though the woman's disappearance from the scene, or her presentation as being already a mother, results purely from the impersonal technology of the ultrasound machine or the equally impersonal medical language borrowed by the Court.[207] But in fact, adoption of those tools and their mobilization in the abortion context result from conscious decisions by state actors, not from nature or chance.

Such laws also put into question the relevance of viability as a boundary line in constitutional doctrine, perhaps displacing it in favor of the cervix as the legally relevant border. This act of border displacement is echoed in the anti-abortion literature, which argues that viability—designated by the Supreme Court as the point before which the state cannot impose an undue burden on abortion access—is an arbitrary line and should be replaced by another. Indeed, one author, writing in 1984, went so far as to erase the woman entirely, stating that "there is no reason from the point of view of physiology why fetal humans should be viewed as different from born humans," and that "nothing physiologically important happens at the exact instant of birth except that the fetus is exposed to the cold air of the world."[208] Note the medically impersonal,

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[205] SANGER, supra note 186, at 113 ("[A]s the use of ultrasound became more commonplace, the methods of obtaining measurements, such as the relation of cranium size to age, became standardized. This meant that doctors themselves no longer needed to conduct the scans; trained sonographers could do the job.").

[206] FOUCAULT, *supra* note 199, at 205 (internal citation omitted).

[207] Dissenting in *Gonzales v. Carhart*, Justice Ginsburg observed that the majority effaces women's agency by assuming that an abortion method ban—rather than a robust informed consent requirement—was the only way to protect women from a lack of information about the nature of the procedure. *Carhart*, 505 U.S. at 184 (Ginsburg, J., dissenting).

[208] John M. Goldenring, *The Brain-Life Theory: Towards a Consistent Biological Definition of Humanness*, 11 J. MED. ETHICS 198, 199, 201 (1985). Goldenring advocates for brain

objective-sounding language: "from the point of view of physiology." Of course, the context demonstrates that the author is referring to fetal rather than maternal physiology—but this is precisely the point. The woman and her experience of pregnancy and birth are so completely absent from the discussion that the apparent irony of these words does not even register for their author.

David Forte has also argued that viability is arbitrary and should be replaced with fetal cardiac activity as the point at which "life" begins.[209] His argument supports the adoption of so-called heartbeat bans, which criminalize abortion beginning around six weeks of pregnancy, when fetal cardiac activity can first be detected. Others have pointed to the supposed ability of the fetus to feel pain at twenty weeks' gestation as support for pre-viability abortion bans.[210] The irony is that this incessant search for a new and more definitive border or marker, with its constant appeals to purported objective medical facts, results only in a proliferation of potential borders, highlighting their arbitrariness. Of course, it is not the existence of the borders themselves that is problematic. The law largely functions through the drawing of lines and designating points at which conduct crosses over from legal to illegal, all of which could be considered arbitrary "borders." The problem with such borders in abortion discourse is the failure to recognize that they represent a moral and political, rather than an objective medical or technical judgment.[211]

V. Reconsidering the Constitutional Landscape

Several common themes emerge from examining the various forms of spatial regulation of abortion. As discussed below, these shared features of spatial regulations help to explain the particular attractiveness of this mode of legislation, perhaps particularly for lawmakers who seek

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life, which, he asserts, begins at approximately eight weeks *in utero*, as the point at which an embryo becomes a human being.

[209] David F. Forte, *Life, Heartbeat, Birth: A Medical Basis for Reform*, 74 OHIO ST. L.J. 121, 140 (2013) ("There is a better marker…. That marker is the point at which the onset of cardiac activity in the fetus occurs. We are speaking of heartbeat.").

[210] John A. Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PA. J. CONST. L. 327, 365 (2011).

[211] *Cf.* Reva Siegel, *Reasoning from the Body: An Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 275 (1992) (explaining, in the abortion context, how "medical analysis displaces social analysis of the exercise of state power entailed in restricting women's access to abortion").

to restrict access without making this purpose apparent. This Part summarizes those features, drawing connections among the three types of spatial restrictions analyzed in this Article, and then considers the constitutional implications of understanding many of the existing abortion restrictions in this way.

A. Why spatial regulation?

It is now possible to sketch an answer to this question. Because of certain features inherent in this type of law, spatial regulation of abortion is particularly appealing when the goal is to restrict abortion access. The effects of spatial regulation often arise from existing social and economic arrangements, such that the role of the state in bringing about those effects appears to be attenuated, if present at all. At the same time, the manipulation of borders and boundaries is submerged under an appearance of inevitability. Spatial regulation, which relies upon and invokes the state's police power to protect the health and safety of citizens, often appears uncontroversial and apolitical. For example, spatial regulations may simply designate certain places as *types* of places, in which certain activity is or is not permitted to occur, with legal consequences that flow from those designations. The drawing of lines and labeling of places appears to be a technical or administrative one, but significant political consequences flow from it—including, often, the exacerbation of preexisting inequalities. Although this exacerbation may not always be an explicit goal of spatial regulation, it is at a minimum a known and expected outcome of it, albeit one that by and large escapes constitutional scrutiny.

When a state passes legislation that has the effect of making it nearly an "abortion-free zone"; when it limits access to abortion even out-of-state; or when the U.S. Government attempts to put young asylum-seekers to the choice of either remaining in the U.S. and forgoing an abortion or leaving the country, it may appear to be exercising exactly the kind of "border control" that sovereigns are expected and entitled to exercise. Yet it is acting not only upon the borders themselves but also upon individuals; it is designating those individuals as either fully entitled to the benefits and protections of the Constitution, or something less.[212]

[212] *Cf.* NICHOLAS K. BLOMLEY, LAW, SPACE, AND THE GEOGRAPHIES OF POWER 54 (1994) ("Legal categories are used to construct and differentiate material spaces which, in turn, acquire a legal potency that has direct bearing on those using and traversing such spaces.").

It is also stigmatizing both abortion and the people who seek it by designating them as outsiders with respect to the political community.[213]

This sort of sovereign line-drawing also occurs with respect to the physical places where abortions take place. If any place where abortions are regularly performed is designated an "ambulatory surgical facility," it is required to conform to licensing and other requirements, which often depend on a relationship with a local hospital.[214] As explained above, differential spatial regulation of abortion clinics has arguably led to the increased isolation of abortion from health care more generally and of abortion providers from "mainstream" health care providers.[215] It then further disempowers abortion providers and patients in making the availability of abortion services dependent on private actors, such as hospitals, that operate outside the field of abortion provision and may themselves be influenced by the abortion stigma that this form of spatial regulation creates.

Finally, the state both draws and manipulates boundaries within pregnant bodies by means of mandatory ultrasound laws and "partial-birth" abortion laws. Particular legal consequences flow from the location of the fetus during an abortion procedure and from the features of the visual and auditory map of the fetus during an ultrasound.[216] Moral consequences also flow from the state's mapping and line-drawing, as the woman symbolically appears to be separate from her fetus; she narratively becomes a mother rather than a pregnant woman, and her abortion is analogized to murder.

In each case, spatial regulation exploits and yet conceals two key features of its operation. First, spatial regulation both relies upon and

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[213] *Cf.* Zick, *supra* note 20, at 537 ("[R]esort to spatiality or territory often produces more than mere regulation of populations and behaviors. Displacement sometimes has a communicative function; it may brand those who are displaced.")

[214] *See supra* Part I.A; *see, e.g.*, Ohio Rev. Code § 3702.30(A)(1)(a); Founder's Women's Health Ctr. v. Ohio State Dep't of Health, No. 01AP-872, 2002 WL 1933886, at *14 (Ohio Ct. App. Aug. 15, 2002) (holding that abortion clinics are "ambulatory surgical facilities" under state law and therefore subject to particular licensing requirements).

[215] *See supra* Part II.B.

[216] Specifically, if the fetal heartbeat is detectable during the ultrasound, the abortion may be prohibited under so-called "heartbeat" abortion bans (all of which have nonetheless been held unenforceable as of this writing). Preterm-Cleveland v. Yost, No. 1:19-CV-00360, 2019 WL 2869640, at *6 (S.D. Ohio July 3, 2019); MKB Mgmt. Corp. v. Stenehjem, 795 F.3d 768, 772–73 (8th Cir. 2015) (North Dakota), *cert. denied*, 136 S. Ct. 981 (2016); Jackson Women's Health Org. v. Dobbs, 951 F.3d 246 (5th Cir. 2020); Planned Parenthood of the Heartland, Inc. v. Reynolds, No. EQCE83074, 2019 WL 312072 (Iowa Dist. Jan. 22, 2019).

conceals the reality that borders are profoundly manipulable. Legal categories—such as "ambulatory surgical center"—may appear neutral and technical, but they are politically determined and often have significant consequences that are far from unavoidable. As Richard Ford has argued, the very "practice of organizing activities as first and foremost occurring in a place defined by its borders is a habit, not a necessity."[217] Likewise, the geography of a given state may seem natural and inevitable; but laws such as admitting-privileges requirements that encourage the concentration of abortion availability in large cities also have predictable and usually intended consequences for abortion access, particularly for poor and rural women.[218] Nonetheless, courts often treat such realities as—in the words of one court—"not a factor of state law."[219] It is precisely the ability to impose and enforce legal categories while minimizing the appearance of state action that makes spatial regulation so attractive for lawmakers wishing to avoid constitutional challenge. "[C]reating a border is not an act of recognizing a difference but once of making a distinction"; yet, at the same time, "[b]orders do their work by making the distinctions seem natural and inevitable."[220]

Second, spatial regulation reinscribes underlying inequalities, while appearing to act neutrally and without reference to categories of race, sex, or poverty.[221] Indeed, nearly all abortion restrictions disproportionately impact poor women and women of color, who are more likely to seek abortions in the first place.[222] Restrictions that require greater travel, including travel to other states, predictably hinder those same groups of women.[223] Although this might not be the explicit

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[217] Richard Thompson Ford, *Law and Borders*, 64 ALA. L. REV. 123, 128 (2012). Ford has produced an extensive literature on the relationship between law and geography, with a particular emphasis on the ways in which law's mobilization of boundaries and space creates and aggravates racial inequalities. *See, e.g.*, Richard Thompson Ford, *supra* note 25.

[218] *See supra* Part II.B.

[219] *Utah Women's Clinic*, 844 F. Supp. at 1491 n.11.

[220] Ford, *supra* note 217, at 139.

[221] *Cf.* BLOMLEY, *supra* note 212, at 190-91 ("The construction of racism through the division and encoding of urban space…can easily be obscured: spatial boundaries and differences can easily appear as natural or simply accidental.").

[222] Sabrina Tavernise, *Why Women Getting Abortions Now Are More Likely to Be Poor*, N.Y. TIMES (July 9, 2019) (stating that "[h]alf of all women who got an abortion in 2014 lived in poverty, double the share from 1994").

[223] *Supra* Part II.B.; *see generally* Linda Greenhouse, *Chasing Abortion Rights Across the State Line*, N.Y. TIMES (Nov. 24, 2016).

intention of lawmakers, it is a known consequence.[224] In many cases, reducing abortion access by imposing on already vulnerable individuals may simply be the simplest tool at hand.[225] And because the law's unequal effects are not its explicit purpose, it evades constitutional scrutiny which might otherwise arise under the Equal Protection Clause of the Fourteenth Amendment[226] or the "purpose" prong of the undue burden analysis (under which an abortion restriction is unconstitutional if it is adopted with the purpose of creating a substantial obstacle to abortion access).[227]

B.Constitutional Contexts

Do the insights presented in this Article about the nature and functioning of spatial abortion regulation lead to any new constitutional implications? Some possibilities present themselves. First, some scholars have already considered the constitutional right to travel in relation to territorial restrictions. Below, I summarize and expand that line of argument. Second, a careful analysis of spatial regulation has yielded the insight that state action is pervasively present yet often invisible. Recognizing this fact might lead to a broader understanding of state action than the case law has adopted to date. In particular, this broader understanding of state action could affect the treatment of non-delegation claims in the abortion context. Third, a close examination of spatial discourse in mandatory ultrasound and procedure-ban cases

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[224] *Cf.* Jeremy Waldron, *Homelessness and the Issue of Freedom*, 39 UCLA L. Rev. 295, 315-18 (1991) (analyzing the impact of spatial regulation on homeless individuals, distinguishing between harm that is *intended* by lawmakers and harm for which lawmakers should be *blamed*).

[225] During the 1977 congressional debate over the Hyde Amendment, Representative Henry Hyde stated, "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the ... Medicaid bill." *See, e.g.*,Magda Schaler-Haynes, Arina Chesnokova, Cynthia Cox, Marla Feinstein, Amanda & Sussex, Julia Harris, *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 U. PA. J.L. & SOC. CHANGE 323, 387 (2012).

[226] Washington v. Davis, 426 U.S. 229, 239 (1976) (holding that a law does not violate the Equal Protection solely due to a disparate racial impact; the law must also have a discriminatory purpose).

[227] Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 877 (1992). ("A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."); *see generally* Note, *After Ayotte: The Need to Defend Abortion Rights with Renewed "Purpose,"* 119 HARV. L. REV. 2552, 2565 (2006) (arguing for renewed focus on the purpose prong of *Casey*'s undue-burden test).

produces the insight that it is moral and political judgments, rather than scientific ones, that lead to the construction of particular ideas about abortion and motherhood. As discussed below, this insight should lead courts to reject the notion that scientific advances have changed our understanding of abortion in ways that are legally relevant.

The discussion that follows here is not intended to present an exhaustive analysis of each of these potential constitutional claims. In fact, each potential claim could likely generate a complete scholarly article of its own. Rather, Part is intended primarily to serve as an overview of how a proper understanding of spatial regulation might affect constitutional, as a potential research agenda on spatial regulation in the abortion context, and as a series of suggestions for new arguments that could be mobilized in both the courts and the political arena to challenge abortion restrictions in the future, including in a possible future in which *Roe v. Wade* has been overturned or radically limited.

1. The Right (Not) to Travel and States' Duties to Afford Access. As an increasing number of states are left with only one abortion clinic, and others continue to adopt increasingly onerous abortion restrictions, the underlying principles of *Missouri ex rel. Gaines* become more pertinent. *Gaines*, which dealt with racial segregation, stands for the propositions that federalism does not necessarily entail a patchwork in which individual access to basic constitutional rights differs widely depending on one's state of residence, and that states may not delegate their responsibility for protecting citizens' freedom to other sovereign states. The understanding of federalism derived from *Gaines* and its application in the abortion context intersects, moreover, with case law and scholarship pertaining to the constitutional right to travel under Article IV, section 2 of the Constitution and under the Fourteenth Amendment to the Constitution.

The possibility of a future in which *Roe v. Wade* has been overruled has already generated scholarly literature considering the possibility that some states may choose not only to ban abortion within the state, but also to prohibit their residents from traveling to other states where abortion is legal in order to access abortion.[228] Seth Kreimer has argued that such an extraterritorial abortion ban would violate several constitutional provisions, including the right to travel protected by

[228] *See* sources cited *supra* note 13.

Article IV, section 2 of the Constitution.[229] Kreimer opines that this right, which includes the right to enter and leave any state of the union and to be treated on equal terms with each state's citizens while there, would be inhibited by a law that attaches criminal penalties to doing precisely that.[230] Other commentators have been more skeptical, noting that courts, including the Supreme Court, have upheld laws restricting travel by a state's adult citizens with the purpose of evading state law.[231] Ultimately, it seems that this relatively open constitutional question would turn on how courts might resolve what Richard Fallon has called "the competing claims of state and national citizenship," in that courts in a post-*Roe* world would be forced to decide whether a state's interest in protecting fetuses outweighs the woman's physical liberty, including the right to travel among the states and to enjoy the privileges and immunities of those states.[232] On one hand, this balancing test may weigh in favor of the woman who seeks to travel, given the significant degree of moral disagreement about this issue; the possibility of travel to another state could be seen as a kind of accommodation to women who disagree with an anti-abortion state's moral judgment.[233] Yet, one might ask, if a state has a constitutionally sufficient interest in enforcing its laws on its own citizens, within its own borders, why should it not have an interest in enforcing its laws when its citizens go to other states?[234]

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[229] U.S. Const. Art. IV, § 2 ("The citizens of each state shall be entitled to all privileges and immunities of citizens in the several states.").

[230] Kreimer, *Law of Choice*, *supra* note 13, at 511; *see also* Saenz v. Roe, 526 U.S. 489, 500 (1999) (explaining that the right to travel under Article IV protects "the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in" another state). It is possible that criminalizing such travel would also violate the component of the right to travel that includes "the right of a citizen of one State to enter and to leave another State," *id.*, which is not specifically identified in the Constitution but has been considered either simply a fundamental component of U.S. federalism, *id.* at 501, or an aspect of the liberty protected by the Due Process Clause of the Fourteenth Amendment, Jones v. Helms, 452 U.S. 412, 418-29 (1981).

[231] Fallon, *supra* note 13, at 638-39; Appleton, *supra* note 13, at 675-76.

[232] Fallon, *supra* note 13, at 639-40.

[233] *See* G. Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337, 340 (2002); Cohen, *supra* note 13, at 1370-71.

[234] Glenn Cohen makes this argument in the context of international travel, where its logic is perhaps even more compellingly supportive of extraterritorial application. Cohen, *supra* note 13, at 1370-71. Moreover, he notes that such accommodation would benefit only individuals with the means to travel and that "it keys enforcement to where the harm is done," which is by and large irrelevant to the moral rightness or wrongness of abortion. *Id.* at 1371.

Ultimately, the answer to this question may depend in part on whether the Privileges and Immunities Clause of Article IV, section 2 is best understood as a grant of individual rights to U.S. citizens or as a federalism constraint on states, meant to protect goodwill and unity among them by prohibiting legislation that advances economic protectionism or otherwise discriminates against out-of-staters. If it is only the latter, then perhaps Article IV only protects against actions by destination states that prevent *citizens of other states* from availing themselves of the benefits of the destination state.[235] If it is the former—if it is, as Part I argues, a protection of the liberty itself in its most fundamental form—then it would appear to limit the extraterritorial reach of abortion prohibitions, because individual citizens of a restrictive state would nonetheless possess an entitlement by virtue of Article IV to travel to other states to enjoy the benefits of the laws of those states, an entitlement which could not be infringed by their home states.[236]

This right-to-travel framework may provide a powerful doctrinal and political argument in a possible future world without *Roe*. It appears to have limited applicability in the current context, however. To be sure, Article IV may prohibit states with highly restrictive abortion laws from requiring their citizens to avail themselves of those laws rather than travel outside the state. But other than in the case of minors, states have not generally attempted to apply their restrictions extraterritorially and, in fact, have instead seemingly encouraged women to travel out of state to access abortion.[237]

On the other hand, one possibility for combatting abortion restrictions that result in a lack of access, or severely reduced access, to abortion in a particular state might derive from a right *not* to travel.[238] This right not to travel is the flip side of the right to travel—just as the First Amendment right to speak includes a right not to speak.[239] A right not to travel would mean that women have a right to access constitutionally protected health care services within their own states and

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[235] Doe v. Bolton, 410 U.S. 179, 200 (1973).

[236] Of course, an additional constraint on the right-to-travel argument is that the Privileges and Immunities Clause protects only citizens of the U.S. Thus, non-citizens, already uniquely burdened by abortion restrictions in some parts of the country, could not avail themselves of the arguments described here.

[237] *See supra* text accompanying note 145.

[238] A theoretical right not to travel (albeit not in the U.S. constitutional context) has been suggested by Nicholas Blomley. *See* BLOMLEY, *supra* note 212, at 210.

[239] U.S. CONST. AMDT. I ("Congress shall make no law … abridging the freedom of speech…."); Wooley v. Maynard, 430 U.S. 705, 714 (1977).

cannot be required to become "reproductive refugees" in order to retain control over their reproductive decisionmaking.

Such a principle may be identified in those cases in which courts have struck down laws that would close the last abortion clinic in a given state, relying on *Gaines*. In *JWHO*, for example, the court held that the availability of abortion services in neighboring states did not absolve Mississippi of its responsibility to avoid imposing an undue burden on abortion access within the state.[240] As the Seventh Circuit similarly explained in a similar case:

> [The idea that] the harm to a constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction ... [is] a profoundly mistaken assumption. In the First Amendment context, the Supreme Court long ago made it clear that one is not to have the exercise of his liberty of expression in appropriate places abridged on the plea that it may be exercised in some other place.… It's hard to imagine anyone suggesting that Chicago may prohibit the exercise of a free-speech or religious-liberty right within its borders on the ground that those rights may be freely enjoyed in the suburbs.[241]

In that case, the Seventh Circuit relied in part on its prior decision in *Ezell v. City of Chicago*, in which it struck down a Chicago law that effectively banned handguns within city limits by requiring handgun owners to have at least one hour of training at a firing range, and then prohibiting firing ranges within the city limits.[242] In that case, the court rejected the idea that the plaintiffs did not suffer any harm because they could travel outside the jurisdiction in order to exercise their Second Amendment rights.[243] It also noted the irony that "the City considers live firing-range training so critical to responsible firearm ownership that it mandates this training as a condition of lawful firearm possession," while

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[240] Jackson Women's Health Organization v. Currier, 760 F.3d 448, 457 (5th Cir. 2014).

[241] Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908, 918–19 (7th Cir. 2015 (quoting Ezell v. City of Chicago*,* 651 F.3d 684, 697 (7th Cir.2011) (quotation marks and internal citations omitted)).

[242] *Ezell*, 651 F.3d at 691.

[243] *Id.* at 697.

at the same time prohibiting such ranges.[244] Similarly, in the abortion context, states consider written transfer agreements and admitting privileges vital to safe abortion practice, while at the same time creating various obstacles to obtaining them, such as forbidding public hospitals from participating.[245]

Abortion restrictions that effectively "forc[e] [women] to leave the state to exercise their constitutional right"—whether because they close all abortion clinics in the state or, for example, make the procedure unavailable after a particular stage of pregnancy—could be considered unconstitutional under this logic.[246] The rationales of *Gaines* and *Ezell* thus provide a tool for challenging laws that hollow out any the right to access abortion, such that a state is left without a single abortion provider. Citizens have a right not to be forced to travel to another state to exercise their federally guaranteed constitutional rights; *Gaines* thus presents a sort of mirror image of the right to travel—a right *not* to be forced to travel in order to access basic rights. Indeed, as Jeremy Waldron has explained in the context of considering states' obligations to refrain from legislation that limits homeless persons' access to public spaces, "Everything that is done has to be done somewhere. No one is free to perform an action unless there is somewhere he is free to perform it."[247] Making and enforcing rules that result in the unavailability of places where an action may legally be performed restricts that activity just as surely as a direct ban might do.[248]

One might argue that *Gaines* should have limited relevance in the abortion context, however, because the state's duty to provide equal protection of the laws—that is, to provide a benefit such as public education on equal terms to all citizens, *if* it provides that benefit at all—

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[244] *Id.* at 704-05.

[245] *See, e.g.*, OHIO REV. CODE § 3727.60(B)(1) (forbidding public hospitals to enter into written transfer agreements with abortion clinics).

[246] *JWHO*, 760 F.3d at 456 (citing Jane L. v. Bangerter, 102 F.3d 1112, 1114 (10th Cir. 1996), which struck down a law significantly restricting abortions after twenty weeks gestation). The current wave of laws banning abortions by the common method known as "D&E" similarly threaten to make abortion unavailable after about fourteen to seventeen weeks of pregnancy. *See, e.g.*, Hopkins v. Jegley, 267 F. Supp. 3d 1024, 1069 (E.D. Ark. 2017), amended, No. 4:17-CV-00404-KGB, 2017 WL 6946638 (E.D. Ark. Aug. 2, 2017) (noting that women "would immediately lose the right to obtain a pre-viability abortion anywhere in the State of Arkansas after 14.0 weeks LMP if the D & E Mandate were allowed to take effect.").

[247] Waldron, *supra* note 224, at 296.

[248] *Id.* at 304-06.

is conceptually quite different from the state's responsibility under the Due Process Clause not to interfere with abortion access, which is provided by private entities. Indeed, this was the counter-argument raised by the dissent in *JWHO*, which declined even to find state action behind the refusal of hospitals to grant legally required admitting privileges to abortion clinics in the state.[249] The dissenting judge in that case noted that in the *Gaines* context, unlike the abortion context, the state was providing a service, and that unlike the Equal Protection Clause, the substantive due process guarantee "does not require a state to *take* any action but rather to *refrain* from taking unconstitutional actions."[250] The dissent thus seems to suggest that applying *Gaines* in the substantive due process context wrongly imposes a positive obligation on states to provide a service, rather than a negative obligation to avoid interfering with women's access to abortion.[251]

Yet, the above discussion of spatial regulation demonstrates that what appears to be a neutral restriction on abortion access often has differential effects on poor women, rural women, and women of color. Moreover, courts and scholars—including, most prominently, the plurality opinion in *Casey*—have also come to recognize that the abortion right *is* a form of equality right, being necessary to women's economic and social equality.[252] Though abortion restrictions are not generally found to be in direct conflict with the Equal Protection Clause, this insight demonstrates the fundamental connection between equality concerns and substantive due process principles. In addition, some right of access is already implied by existing abortion jurisprudence; *Whole Woman's Health*, after all, held that a law was unconstitutional because it

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[249] *JWHO*, 760 F.3d at 461 (Garza, J., dissenting) ("Regardless of the propriety or legality of the hospitals' actions, what matters for this substantive due process analysis is that JWHO has not shown that the Clinic's closure would result directly from [the statute], as opposed to the independent decisions of local hospitals—non-state actors.").

[250] *Id.* at 463.

[251] For a discussion of the distinction between positive and negative rights, and the fact that the U.S. Constitution is often (if somewhat incorrectly) understood to confer only the former, *see*, *e.g.*, Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997, 1003-12 (2010).

[252] Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992); *see also* Appleton, *supra* note 13, at 660-62.

would shut down too many abortion clinics, creating a substantial obstacle to abortion access in the state.[253]

Still, there must be meaningful limits to this principle. Otherwise, it suggests that states must always provide whatever individuals need in order to exercise their rights. If there is no clinic or gun manufacturer in a given state for reasons that have nothing to do with the laws of the state, is the state required to build one? Does the right not to travel in order to access abortion services imply that each state must adopt the regulations of the most liberal state in the union? Obviously, further specification of this claim would be necessary. It seems, however, that the notion of a right not to travel, combined with the equality-inspired doctrinal tradition of *Gaines*, might provide a basis for arguing that states have an obligation to ensure at least a minimum level of abortion availability and access as an incident of citizenship.

2. Private Non-delegation claims. In the abortion context, plaintiffs have sometimes raised a species of "private non-delegation" claim to challenge spatial regulations. Such claims have a long pedigree, but the doctrinal line has recently begun to falter. For over a century, courts have accepted the notion that the government cannot, consistent with the Due Process Clause, grant standardless discretion to private entities to enforce certain kinds of legal rules in ways that infringe others' constitutional rights. However, this rule has largely remained under-developed, and in the abortion regulation context, it seems to be losing force. As the above discussion indicates, however, this doctrine captures an important but often unrecognized problem with many spatial abortion regulations: in relying on neutral-seeming rules that delegate authority to private parties, they conceal the role of the state in exploiting pre-existing hostility to abortion and other features of the geographical context to intentionally reduce abortion access.

In the 1912 case *Eubank v. City of Richmond*,[254] the Supreme Court held unconstitutional a city ordinance that allowed two-thirds of property owners on a street to dictate a demand a particular setback for future building.[255] This decision directly affected the plaintiff, who had purchased land and begun planning a home that would not conform to the setback.[256] Although the lower courts had upheld the law, the

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[253] Whole Woman's Health v. Hellerstedt, ---U.S.----, 136 S. Ct. 2292, 2299 (2016), *as revised* (June 27, 2016).
[254] 226 U.S. 137 (1912).
[255] *Id.* at 141, 144.
[256] *Id.* at 142.

Supreme Court found it to be an unconstitutional use of the state's police power, emphasizing that the law allowed "[o]ne set of owners [to] determine[] not only the extent of use, but the kind of use which another set of owners may make of their property."[257] In particular, the Court was concerned that the law imposed no standard on those private parties' use of their power, allowing them to act capriciously, out of self-interest, or simply out their own arbitrary sense of taste.[258] Indeed, the Court noted, if an individual owned enough property, that single person could dictate the rights of a number of property owners.[259]

The Supreme Court subsequently relied upon *Eubank* in another case from the same era—*State of Washington* ex rel. *Seattle Title Trust Co. v. Roberge*.[260] There, the Court found a similar law—allowing certain kinds of buildings to be constructed only with the consent of nearby property owners—to be unconstitutional.[261] Noting that the neighbors' authority was "uncontrolled by any standard or rule prescribed by legislative action," with no possibility of review, the Court again expressed concern that the private property owners were "free to withhold consent for selfish reasons or arbitrarily."[262] Thus, the Court held, the law violated Fourteenth Amendment by attempting an "unconstitutional delegation of power."[263]

Both cases arose during an era in which courts engaged in close scrutiny of states' use of their police power, freely striking down laws that did not advance health, safety, or morals. Moreover, they preceded the modern era of equal protection and substantive due process jurisprudence. Nonetheless, they embody principles that retain vitality today. As noted below, courts continued to recognize, well into the twentieth century, that any delegation of governmental authority to private parties must be exercised pursuant to governmentally prescribed standards; otherwise, it is arbitrary and unconstitutional, just as any other arbitrary use of governmental power would be.[264]

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[257] *Id.* at 143.
[258] *Id.* at 143-44.
[259] *Id.*
[260] 278 U.S. 116 (1928).
[261] *Id.* at 122-23.
[262] *Id.*
[263] *Id.*
[264] *See, e.g.*, Bell v. Wolfish, 441 U.S. 520, 584 n.15 (1979) (Stevens, J., dissenting) (citing *Rinaldi v. Yeager*, 384 U.S. 305 (1966), and *Illinois Elections Board v. Socialist Workers Party*, 440 U.S. 173 (1979)).

This principle has sometimes been used to strike down abortion regulations that require clinics to seek the permission of a private third party in order to operate, such as by requiring admitting privileges or hospital transfer agreements. In a case decided shortly after *Roe v. Wade*, for example, a district court held that a law requiring abortion clinics to have either a transfer agreement or hospital admitting privileges for its physicians violated due process.[265] Noting that the law imposed no standards for the grant or denial of agreements or privileges by hospitals and no opportunity for judicial or administrative review, the court analogized to cases in the First Amendment context striking down licensing schemes that grant standardless discretion to state officials.[266] "The state cannot grant hospitals the arbitrary power to veto the performance of abortions for any reason or no reason at all, it explained; "The state cannot grant hospitals power it does not have itself."[267]

But more recent case law is mixed. Some courts have struck down spatial abortion restrictions on this basis. In *Planned Parenthood of Wisconsin v. Van Hollen*, for example, the district court struck down Wisconsin's admitting privileges law on precisely this basis.[268] The Eighth Circuit rejected a similar challenge to an admitting privileges requirement—but one that was imposed directly on physicians who perform abortions rather than on clinics—by asserting that the law "involve[d] state regulation of the qualifications of persons who perform abortions rather than standards for licensure of abortion clinics."[269] More commonly, though, both courts and parties have shown discomfort with such claims, either cursorily rejecting them or simply avoiding them. For example, the Seventh Circuit simply glossed over the nondelegation

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[265] Hallmark Clinic v. North Carolina Dep't of Human Resources, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974).

[266] *Id.* at 1158.

[267] *Id.* at 1158-59; *see also* Birth Control Centers, Inc. v. Reizen, 508 F. Supp. 1366, 1374 (E.D. Mich. 1981) (striking down a written-transfer agreement requirement as "violat[ing] due process concepts because they delegate a licensing function to private entities without standards to guide their discretion").

[268] Planned Parenthood of Wisconsin, Inc. v. Van Hollen, 94 F. Supp. 3d 949, 997 (W.D. Wis.), *aff'd sub nom.* Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908 (7th Cir. 2015).

[269] Women's Health Ctr. of W. Cty., Inc. v. Webster, 871 F.2d 1377, 1382 (8th Cir. 1989); *see also* Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott, 748 F.3d 583, 600 (5th Cir. 2014) (rejecting a nondelegation claim on the same grounds as *Webster*); Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control, 317 F.3d 357, 363-64 (4th Cir. 2002) (rejecting a nondelegation challenge because the likelihood of hospitals exercising an arbitrary veto was remote).

argument in affirming the *Van Hollen* decision on other grounds.[270] In other recent cases, courts have simply declined to reach such claims,[271] or plaintiffs have declined to press them.[272]

Private nondelegation doctrine is particularly well suited to application in the context of spatial regulations for several reasons. First, private nondelegation doctrine has primarily been applied in the zoning and licensing contexts—contexts which are subject to spatial regulation—since they implicate property rights of which individuals cannot be denied without due process of law.[273] (Indeed, as such, they do not even depend on the constitutionally protected status of the abortion right and could be used post-*Roe* to challenge spatial restrictions in states where abortion is legal but heavily restricted.) More importantly, when they operate to shut down abortion clinics, delegations to private actors rely on several factors unique to spatial regulation in the abortion context. For example, admitting privileges and written transfer agreement laws may specify a particular maximum distance that the hospital can sit from the clinic. Inevitably, such distance specifications limit the universe of institutions from which clinics may seek assistance to stay in business, thus increasing their vulnerability to closure at the whim of powerful actors within those institutions. More fundamentally, such spatial requirements also rely upon the geographical isolation of clinics, including the fact that abortions are largely performed outside the hospital setting—a fact largely attributable to the precise hostility to

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[270] Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908 (7th Cir. 2015).
[271] *See, e.g.*, EMW Women's Surgical Ctr., P.S.C. v. Glisson, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *28 n.29 (W.D. Ky. Sept. 28, 2018) (declining to reach nondelegation claim).
[272] Jackson Womens' Health Org. v. Currier, 940 F. Supp. 2d 416, 420 (S.D. Miss. 2013), order clarified sub nom. Jackson Women's Health Org. v. Mary Currier, MD., M.P.H., No. 3:12CV436-DPJ-FKB, 2013 WL 12122002 (S.D. Miss. Aug. 13, 2013), and aff'd as modified sub nom. Jackson Women's Health Org. v. Currier, 760 F.3d 448 (5th Cir. 2014) ("[W]hile [the clinic] may have a valid due-process claim, it expressly reserved the claim in its Reply, which may indicate that it is somehow infirm. The Court will stop here, but to avoid piece-meal adjudication, the Court advises Plaintiffs to assert their arguments if they deem them worthy.").
[273] *See, e.g.*, Women's Med. Prof'l Corp. v. Baird, 438 F.3d 595, 611 (6th Cir. 2006) ("[D]ue process protects an interest in the continued operation of an existing business."); Spinelli v. New York, No. 07-CV-1237, 2009 WL 2413929, at *6 (2d Cir. Aug. 7, 2009).

abortion on the part of hospitals and hospital-based physicians that make it so hard for clinics to meet these requirements.[274]

The private nondelegation doctrine, properly understood, represents a potentially powerful tool for challenging spatial abortion regulations. The idea that the government may not act arbitrarily, either on its own or by delegating arbitrary and standardless authority to private parties, has survived the vicissitudes of constitutional doctrine over more than a century. It can be identified in cases such as *Larkin v. Grendel's Den*, in which the Supreme Court struck down a statute allowing churches to veto the issuance of liquor licenses to nearby businesses,[275] and *Palmore v. Sidoti*, in which the Court held that presumed private racial biases could not be allowed to dictate official decisionmaking with respect to child custody.[276] Although *Larkin* and *Palmore* were not decided on due process grounds, they demonstrate that the principle forbidding delegation of an arbitrary veto over a third party's liberty has been incorporated into numerous doctrinal spaces.

Moreover, the case law demonstrates the relationship between the due process concern at the heart of the private nondelegation doctrine and equality concerns. Both the early cases, such as *Roberge*, and more modern cases, such as *Hallmark Clinic*, cite to *Yick Wo v. Hopkins* as authority for the notion that the right to do business cannot be delegated to private or public individuals' arbitrary whim.[277] *Yick Wo*, of course, was a case involving an ordinance forbidding laundries to operate in wood-frame buildings, unless the board of supervisors consented to it.[278] The petitioner alleged that the prohibition was enforced only against

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[274] *See* GINSBURG, *supra* note 87 & n.21 (explaining that hospitals' refusal to perform abortions after *Roe* was largely attributable to "the convictions of individual medical personnel or … the fears of hospital officials and governing bodies that too high an abortion rate would give their institution the reputation of being an 'abortion mill'"); Ziegler, *Liberty*, *supra* note 3, at 442 (noting that the anti-abortion strategy behind TRAP laws relied on the fact that "the burden created by a law resulted not from the statute itself but rather from economic and political circumstances over which the government had no control");

[275] Larkin v. Grendel's Den, Inc., 459 U.S. 116, 127 (1982) (striking the law on Establishment Clause grounds and finding that it "substitute[d] the unilateral and absolute power of a church for the reasoned decisionmaking of a public legislative body acting on evidence and guided by standards").

[276] Palmore v. Sidoti, 466 U.S. 429, 433 (1984).

[277] *Hallmark Clinic*, 380 F. Supp. at 1158 (citing Yick Wo v. Hopkins, 118 U.S. 356, 370 (1886)); *Roberge*, 278 U.S. at 122 (citing *Yick Wo*, 118 U.S. at 366).

[278] *Yick Wo*, 118 U.S. at 356.

businesspeople of Chinese descent.[279] Though the Supreme Court did not focus on the racial discrimination committed by city officials, it did find that the ordinance conferred "a naked and arbitrary power to give or withhold consent, not only as to places, but as to persons," and therefore violated the petitioner's Fourteenth Amendment rights.[280] In fact, while citing both the Due Process and Equal Protection Clauses, it made explicit the connection between standardless discretion and discrimination, noting that the ability to make arbitrary decisions allowed officials to discriminate against Chinese business owners, treating otherwise similarly situated businesses differently.[281] This connection between arbitrariness and discrimination is evident in *Palmore* as well.[282]

To be sure, this principle may also raise some new concerns, such as whether it has coherent limits that can be consistently applied by courts. To some extent, the case law itself identifies such limits. Generally, courts have found that a nondelegation challenge will fail if the private delegation is subject to judicial or administrative review (in which codified standards may be applied),[283] or if there is reason to believe that the authority will not be exercised arbitrarily.[284] Comprehensive development of the private nondelegation doctrine and its application to spatial regulations must therefore await another article; the goal of this Part has been to show that it may provide a basis for challenge to some regulations that otherwise appear likely to survive under current doctrine.[285]

3. Scientific boundaries. A final insight regarding spatial abortion regulation that might yield some constitutional payoff is the recognition that boundaries—whether geographical or anatomical—are products of legal and moral decisionmaking, not irrefutable facts that must be taken for granted. Borders "are made, not found."[286] This insight might give

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[279] *Id.* at 356.
[280] *Id.* at 366.
[281] *Id.* at 373-74.
[282] Shelley v. Kraemer, 334 U.S. 1, 21 (1948) (holding that judicial enforcement of a racially restrictive covenant would violate the Equal Protection Clause of the Fourteenth Amendment).
[283] *See, e.g.*, Women's Med. Prof'l Corp. v. Baird, 438 F.3d 595, 610 (6th Cir. 2006) (holding that the state's ability to grant a waiver from the written transfer agreement requirement saved it from invalidation as an impermissible delegation); *Hallmark Clinic*, 380 F. Supp. at 1158 n.8.
[284] *See, e.g.*, Tucson Women's Clinic v. Eden, 379 F.3d 531, 555-56 (9th Cir. 2004).
[285] *Supra* Part XX.
[286] Ford, *supra* note 100, at 127.

some cause for skepticism about attempts to draw a different line than viability for when abortion is permissible under the Constitution and about a recent spate of claims that scientific advances have shown definitive support for a different such borderline.

In *Planned Parenthood v. Casey*, the Supreme Court recognized the inevitable criticism of the viability line as being a moving target, while strongly reaffirming that the core of the privacy right was the woman's ability to choose abortion before viability.[287] When faced with argument urging it to overturn the viability framework, the Court held that there was no line that better balanced the interests of the woman and the state, and no advances in medicine had changed that fact, regardless of when, exactly, viability occurred.[288]

Yet, advocates for restricting abortion rights have argued that the viability line is arbitrary, promoting a different line between legality and illegality for abortion. They have attempted to identify particular "anatomical landmarks" that indicate the point at which an abortion supposedly occurs "outside the body" of the woman.[289] They have also argued that the viability line should be replaced by a different line, such as the presence of fetal cardiac activity, supposedly due to "[r]ecent medical research."[290] The analysis in this article indicates, however, that these lines are and have always been moral and political ones, rather than scientific or medical ones. The tendency of spatial regulation to mask that reality and to suggest that line-drawing is a technical task should not override the logic and reasoning supporting existing legal rules in the abortion context. Though the recognition of this feature does not

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[287] Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 860-61 (1992).
[288] *Id.*
[289] *Supra* text accompanying notes 177-183. *See also* Gonzales v. Carhart, 550 U.S. 124, 186 (2007) (Ginsburg, J., dissenting) ("Instead of drawing the line at viability, the Court refers to Congress' purpose to differentiate 'abortion and infanticide' based not on whether a fetus can survive outside the womb, but on where a fetus is anatomically located when a particular medical procedure is performed.").
[290] Forte, *surpa* note 209, at 140; *see generally* Marc Spindelman, *On the Constitutionality of Ohio's Proposed "Heartbeat Bill"*, 74 OHIO ST. L.J. 149, 150 (2013); John A. Robertson, *Science Disputes in Abortion Law*, 93 TEX. L. REV. 1849, 1849 (2015) ("Initially, the abortion debate concerned whether fetuses were living human beings. Opponents of abortion appealed to the science of biology, which showed that fetuses are indeed human, living, and individual. However, this biological fact did not mean that they are persons within the protection of the law."); Robertson, *supra* note 210, at 390 ("Legal disputes arising from fetal sonograms, viability, fetal pain, and early prenatal diagnosis are less about the state of the science than they are about the meaning of that science within an existing structure of constitutional doctrine.").

provide an independent constitutional basis for challenging mandatory ultrasound laws or abortion procedure bans, it should inform their analysis and may provide a tool for combating them in the political realm.

Conclusion

The "spatial turn" in abortion regulation has yielded benefits for those seeking to restrict access to abortion while creating new difficulties for those wishing to challenge abortion restrictions. The goal of this Article has been to examine the implications of this consequential shift and to consider some possible ways in which attending to the dynamics of spatial regulation could affect constitutional analysis in the abortion context. As the future of *Roe v. Wade* itself hangs in the balance, the need for new legal and political arguments for protecting reproductive liberty becomes even more pressing. Spatial regulation is simply too attractive a tool for legislators to resist.